ANNEX M
HEALTH AND MEDICAL

I. SITUATION AND ASSUMPTIONS

A. A major technological, natural disaster or terrorist incident may cause an immediate demand for health and medical services in excess of normal demand.

B. Residents or patients at health care facilities might be evacuated due to damage or the threat of damage from an incident.

C. A disaster incident can give rise to secondary sources of infection and disease if proper precautionary steps are not taken in time.

D. The number of beds in the Commonwealth for burned or radiological contaminated casualties is sufficient under normal conditions, but might not suffice if there is a major disaster.

E. The implementation of Annex Y (Mass Destruction/Conventional War), or Annex AA (Homeland Security), would cause serious disruptions at major medical and health care facilities, which are located in the areas most likely to be targeted in a nuclear attack.

F. A major conventional war or terrorist attack could impose a serious strain on the Commonwealth's health care facilities as wounded are returned to the U.S. for treatment.

G. The number of casualties and fatalities resulting from a major epidemic or natural, technological, terrorist, or war-related incident might overwhelm medical and mortuary services. The facilities for caring for the dead and injured might also sustain physical damage. Emergency responders, medical and mortuary personnel might be among the casualties.

H. Difficulties in identifying the deceased might necessitate the services of forensic specialists.

I. Casualties and fatalities contaminated by a chemical/biological incident might pose a health hazard to those trying to render medical aid or mortuary service to the victims.

J. A mass casualty event may require implementation of Emergency Medical Care (See Appendix M-4).

K. A major disaster may require activation of the National Disaster Medical System (NDMS) if state resources are overwhelmed. It is designed to care for a large number of casualties from either a domestic disaster or an overseas war.

L. Following a catastrophic disaster, the Federal Response Plan might be

implemented to immediately assist state and local response efforts to save lives and protect property. Within that plan, one of the Emergency Support Functions (ESF) is Health and Medical Services (ESF #8). This ESF provides for emergency medical services using the framework of NDMS. Services include triage, evacuation and medical treatment of victims, provision of supplemental nursing and medical supplies and personnel and assistance in responding to public health threats (water, sanitation, human and animal remains, disease control and environmental pollution).

1. The primary federal agency for managing the ESF of Health and Medical Services is the Department of Health and Human Services (DHHS).

2. The support agencies responsible for assisting DHHS in providing health and medical services are: the U.S. Department of Agriculture (USDA), the Department of Defense (DOD), the Department of Interior (DOI), the Department of Justice (DOJ), the Department of Transportation (DOT), the Veterans Administration (VA), the Office of Foreign Disaster Assistance (OFDA), the American Red Cross (ARC), the Environmental Protection Agency (EPA), U.S. Army Corps of Engineers (USACE), the Department of Homeland Security (DHS), the Federal Emergency Management Agency (FEMA), the National Communications Systems (NCS) and the U.S. Postal Service (USPS).

3. State counterparts who will work with the federal agencies include the Health and Family Services Cabinet (H&FSC), which will manage the ESF of Health and Medical Services, and the following agencies that will provide necessary support.

    a. The state Department of Education can provide buildings and large open spaces where casualty collection sites could be established and school buses that could be used to transport the less seriously injured. Note that if a disaster occurs during the school day these resources might not be immediately available.

    b. The state Medical Examiner's Office in the Justice Cabinet will provide support to the local coroners in identifying the deceased, processing the paperwork and finishing the details.

    c. The Kentucky National Guard (KyNG) will provide medical support; including personnel specialized in first aid and stabilization of victims at the scene of the disaster. Casualties can be moved to a field hospital by either ground ambulances or the KyNG air ambulances. Once triaged and stabilized, victims can be evacuated either to nearby hospitals by MEDEVAC or long distances by C-130 aircraft. In addition, the KyNG has a water purification unit that can be used if water treatment plants are inoperable.

M. Surge, an extraordinary increase in preparedness activities to meet an impending threat, is described in Section 19, "Actions to Increase Health Medical Readiness" of the Guide for Increasing Local Government Civil Defense Readiness During Periods of International Crisis. It outlines crisis actions that may be taken by local government health departments, supported by organizations of physicians and other health professionals to increase readiness to deal with the health and medical problems which could be created by a nuclear attack on this country.

N. With the activation of any component of this Annex the National Incident Management System will be used to coordinate actions taken.

II. MISSION

A. The mission of Health and Medical Services is to coordinate and direct health care and mortuary activities.

B. To provide emergency care and treatment of casualties resulting from a natural or technological disaster, including biological, chemical or radiological incidents that could occur during a war or terrorist attack.

C. To help continue provision of routine emergency and medical care for the general population.

D. To provide emergency public health services that will prevent and mitigate the spread of infectious diseases.

E. To assist in preventing and remedying the effects of biological, chemical, and radiological incidents or warfare.

F. To provide mental health services for both victims and emergency responders.

III. DIRECTION AND CONTROL

A. Federal Organization.

1. If a disaster is of such magnitude that it exceeds the state's capacity to respond, the National Disaster Medical System can be activated (See Appendix M-1) to provide medical care for casualties.

2. In the event of a catastrophic disaster, the National Response Plan will be activated to supplement state and local efforts.

3. A Federal Coordinating Officer (FCO) will coordinate the cooperative federal/state effort, under ESF 8, Medical, of the National Response Plan.

B. State Organization.

1. In the event of a potential or actual emergency, the H&FSC is the state agency with primary responsibility for providing public health and radiological services for a peacetime incident and for coordinating medical care services.

2. KyEM coordinates the functions of state government involved in disaster response operations, serves as the coordinating agency for local, state, federal and private agencies and is responsible for radiological services in the event of a nuclear attack.

3. The Medical Examiner's office in the Justice Cabinet is responsible for coordinating the support of coroner services and mortuary functions.

C. County Organization.

During activation of a local EOC, the local EM organization will have on staff a health/medical services coordinator to assist in providing necessary health and medical services to residents of the county.

D. Regional Organization.

1. If a disaster affects a multi-county area, the H&FSC Regional Medical Coordinator would call upon medical personnel and draw upon supplies and equipment identified for use in a major disaster.

2. The Coordinator would also assist affected counties by coordinating provision of services and supplies from neighboring counties, state, federal and volunteer agencies.

E. Voluntary Organizations.

1. The American Red Cross (ARC) undertakes relief activities for the purpose of mitigating human suffering caused by disasters, including those that are not severe enough to receive a Presidential disaster declaration. Emergency assistance is provided to evacuees, disaster victims and emergency workers. ARC's assistance provides for the most basic human needs, including food, shelter and supplies.

2. The Salvation Army has teams of doctors and nurses (both Salvation Army and volunteers) who can provide medical services at the scene of the disaster. The medical personnel can be on the road within 2 hours. Their supplies are packed and ready to go and they can arrive on the scene within 24 hours and possibly within 12 hours. They can set up dispensaries and first aid stations and be self-sustaining in provision of services for up to 72 hours. They can provide nurses for the shelters. Importantly, all of the officers in the Salvation Army are ordained clergy who are receiving training to provide post traumatic stress disorder counseling and disaster counseling.

3. National Voluntary Organizations Active in Disaster (VOAD), and Medical Reserve Corps will provide volunteers and various services.

IV. CONCEPT OF OPERATIONS

A. Levels of Operation.

1. At the federal level, a catastrophic event will result in activation of the Federal Response Plan under which a broad spectrum of federal assistance will be rapidly available to assist state and local response efforts. The Federal Response Plan identifies 12 Emergency Support Functions (ESFs), such as Health and Medical Services, Transportation and Energy. Federal and state coordinators will work together to support the local response efforts. A Federal Coordinating Officer (FCO) will coordinate the overall delivery of federal response assistance to an affected state. Federal medical care assistance will be provided through the National Disaster Medical System (NDMS).

2. At the state level, the H&FSC will coordinate and direct public health and radiological services through the county health departments in order to ensure the availability and utilization of such resources. It will also coordinate and assist in provision of resources for medical care. The Medical Examiner's Branch of the Justice Cabinet will support the local coroners in mortuary functions. KyEM will coordinate relief and recovery activities of various local, state, federal and volunteer agencies. Duties of state agencies include the following.

   a. Keeping constantly informed of local conditions and needs.

   b. Ensuring that personnel and supplies are channeled to points of greatest need.

   c. Giving technical assistance where needed.

   d. Arranging for the shifting of medical and auxiliary personnel and technicians to points of need.

   e. Assisting the supply service in determining areas in greatest need of essential supplies.

   f. Arranging for evacuation of casualties.

   g. Requesting aid from surrounding states or the federal government if requests cannot be filled from within the Commonwealth.

3. At the county level, counties are responsible for the actual operation of the public health, medical care, radiological and mortuary services. When needs

exceed their capabilities, local jurisdictions will contact the State EOC to request assistance.

4. At the regional level, the H&FSC Regional Medical Coordinator can help the local jurisdiction obtain medical supplies, equipment and personnel and transport casualties.

5. The American Red Cross (ARC) and Salvation Army both undertake relief activities for the purpose of mitigating human suffering caused by disasters. Emergency assistance is provided to evacuees, disaster victims and emergency workers.

B. Types of Operations.

1. Health Intelligence.

a. As a routine function, each employee of the local health departments shall be alert to health-threatening disasters or emergency events. Any knowledge of such events shall be reported, through proper channels, to the H&FSC, regardless of whether state assistance is requested or is required.

b. If the emergency's threat to public health exceeds the local jurisdiction's response capabilities, the local health and medical coordinator notifies the State EOC.

c. Disaster teams, composed primarily of personnel from the H&FSC, may be used to make on the spot investigations of serious health hazards and problems.

2. General Health and Sanitation

a. Local health department personnel will perform their usual services, such as maintaining records, performing inspections, providing information, etc.

b. When assistance or additional guidance is required, local health and medical coordinators will notify the State EOC, which will arrange assistance and/or provide necessary guidance in the following areas.

1) Epidemic and health hazard reporting and analysis system.

2) Laboratory services that are incidental to the care of casualties and control of diseases, such as water, rabies and blood testing.

3) Vaccines, such as tetanus, needed for disease control.

4) Teams of health specialists to investigate and assist in overcoming

severe local health problems and to re-establish local public health agencies.

5) Standards and guidance in the administration of emergency care for disaster victims.

6) Nutritional standards for the guidance of emergency mass care service (special consideration to be given to the types of foods and minimum caloric requirements for the general population and such special groups as infants, children, pregnant women, the aged, and patients requiring special diets).

7) Emergency procedures for first aid in shelter situations where professional help might not be available.

8) Minimum sanitation standards in food service establishments, shelters, aid stations and related facilities.

3. Epidemiology.

a. Local health departments will keep necessary records on disease outbreaks and will maintain liaison with private practitioners and with the State EOC to coordinate responses to emergency situations.

b. Health and Family Services Cabinet (H&FSC)

1) Establishes standards and issues guidelines in procedures for the prevention of epidemics.

2) Assists in identification and control measures.

3) Arranges assistance where required.

c. Other state agencies will provide aid as requested.

4. Vector Control.

a. Local health departments will maintain an awareness of vector control problems and request assistance when required.

b. The H&FSC provides guidelines and assistance to local jurisdictions on vector control and determines the standards that prevent or limit the spread of disease and infestation by insects and rodents.

5. Blood Management.

a. Sources of blood.

1) American Red Cross Blood Centers in Louisville; St. Louis, Missouri; Ft. Wayne, Indiana; Evansville, Indiana; and Cincinnati, Ohio.

2) Central Kentucky Blood Bank in Lexington.

3) Through the sponsoring agencies of NDMS, additional blood supplies may be available.

b. Transportation.

1) Some of the vehicles used to transport victims to the Casualty Evacuation Site could be equipped to transport blood to the disaster site; refrigerating blood to the proper temperature is essential.

2) Major airports in each region will be the initial shipping/receiving points for blood.

c. Refrigeration.

1) Blood must be kept refrigerated.

2) Adequate refrigeration storage capacity must be located within the immediate vicinity of airports for blood awaiting transportation to the disaster sites.

3) At the local level, storage space may be available at grocery stores and restaurants.

4) Companies with ice-making capabilities can supply ice needed to maintain the appropriate temperature during transport.

6. Emergency Medical Care.

See Appendix M-4, Emergency Medical Care.

7. Mass Fatalities.

See Appendix M-3, Mass Fatalities.

C. Tasks.

1. Local Government.

a. Maintain an awareness of the public health problems in the area and take steps to identify actual or potential problems.

b. Report the following information to the State EOC.

1) Describe the type of emergency and the urgency of the situation.

2) The number of people affected.

3) Major public health hazards, imminent or present.

4) Ability of local authorities to cope with the situation.

5) Health and supporting resources needed.

6) Name of the local contact person.

c. If state assistance is required or requested, periodic status reports will be made.

2. State Government.

a. Health and Family Services Cabinet (H&FSC)

1) Serve as the lead agency for health intelligence matters.

2) Maintain contact with local health officials and keep KyEM and the Director of Health Services informed.

3) Provide guidance and assistance to local health departments.

4) Test private water supplies.

5) Investigate disease outbreaks.

6) Assess damage to health related facilities; such as hospitals and long term care facilities.

7) Provide assistance to local officials.

8) Coordinate and assist in obtaining resources for medical care.

9) If evacuation is ordered, provide direction on relocating patients residing or hospitalized at various types of medical facilities.

b. Environmental & Public Protection Cabinet (E&PPC).

1) Monitor for air and water pollution and keep KyEM informed of any disaster-related or potential disaster problems.

2) Assess damage to water treatment plants, sewage and waste treatment facilities.

3) Monitor landfills receiving disaster debris.

4) Provide trained personnel for a disaster team that will assess damage and give technical assistance.

c. Department of Agriculture.

1) Monitor disaster-related or potential disaster health problems relating to animal or crop disease, food or drug contamination or hazards posed by exposure to pesticides or fertilizers.

2) Provide trained personnel for a disaster team that will assess damage and give technical assistance.

d. Justice Cabinet provides trained personnel for emergency mortuary services.

e. KyEM coordinates and assists in response efforts of federal, state and local agencies and helps in locating potable water supplies.

D. Operational Readiness Phase.

1. Preparedness Phase.

a. Identify and inventory all health and medical resources. For a resource listing, see Kentucky Health Facilities, Health Services, Major Medical Equipment, and Need Projections. It contains a listing of existing licensed health facilities, rural clinics, home health agencies, ground and air ambulances, beds and highly specialized equipment.

b. Prepare plans to discharge less seriously ill patients from various types of medical facilities and determine which facilities can be converted for temporary patient care.

c. Plan for the utilization of essential public health personnel, supplies and equipment to provide health and environmental sanitation services. These services would include vector control measures and communicable disease surveillance.

d. Alert NDMS representative of situation that may require activation of NDMS.

e. Coordinate medical and health plans with surrounding states.

f. Develop an emergency response organization.

g. Develop Standard Operating Procedures (SOPs) for rapid deployment of health personnel to disaster areas.

h. Develop assignment tasks and functions for volunteer medical personnel including physicians, nurses and dentists who would be available to augment the existing medical staffs.

i. Train and exercise staff.

j. Upon instructions from KyEM Director, or representative, shift to Response Phase.

2. Response Phase.

a. Increased Readiness Period.

1) Complete any procedures under Preparedness Phase not yet completed.

2) Review and update Annex M.

3) Alert personnel needed to carry out the annex tasks.

4) Take initial steps to establish temporary health care facilities.

5) Carry out needed training.

6) Insure necessary supplies are available.

7) Upon instructions from KyEM Director, or representative, shift to Emergency Operations Period or return to Preparedness Phase.

b. Emergency Operations Period.

1) Complete any procedures under Preparedness Phase or Increased Readiness Period not yet completed and commence life saving and damage limiting operations.

2) Provide emergency health care.

3) Coordinate all health and medical resources, to include activation of NDMS, if necessary.

4) Implement surveillance and control measures for communicable diseases. Ensure that proper sanitation is provided in the disaster

area.

5) Provide mortuary services and burial of the dead.

6) Discharge patients who are not seriously ill from health and medical facilities if bed space is needed for disaster victims.

7) Under enemy attack conditions, move patients to best possible shelter.

8) Under enemy attack conditions, health personnel remaining in risk areas to care for patients who can not be moved should go to the best available shelter. Actions may be limited in shelter activities.

9) Keep records on workers made available, work undertaken, and hours worked.

10) Upon instructions from KyEM Director, or representative, shift to Recovery Phase.

3. Recovery Phase.

a. Undertake operations as directed by State EOC.

b. Revert to Response or Preparedness Phase upon direction of State EOC.

c. Continue to assist in provision of medical care if demand exceeds what local medical facilities are able to provide.

d. Continue to assist in monitoring for air and water pollution, potential health hazards due to contamination of food or water, and possible disease sources, if needed.

e. Provide and coordinate assistance to individuals, local jurisdictions and businesses suffering disaster losses.

f. Upon return to Preparedness Phase, survey organization for cost of preparing for and conducting recovery operations.

g. Critique operation for updating plans and standard operating procedures.

E. Increased readiness levels will be initiated by KyEM based on information furnished by the federal government or outside sources. The required actions are explained in Annex D of this plan.

F. All emergency operations will be carried out in conformity with KyEM EOC SOP and H&FSC SOP. The H&FSC coordinator is responsible for updating the agency's SOP.

V. ADMINISTRATIVE SUPPORT

A. Sections of the H&FSC, and existing medical/health agencies in the Commonwealth, will be tasked for administrative support.

B. Under the ESF concept, each federal agency is responsible for its own administrative support.

VI. GUIDANCE DOCUMENTS

A. Kentucky Health Facilities, Health Services, Major Medical Equipment and Need Projections, Commission for Health Economics Control in Kentucky, Cabinet for Human Resources.

B. Commonwealth of Kentucky -- Medical Response Plan, 1991.

C. Disaster Services Regulations and Procedures, Subject: Disaster Health Services, ARC 3050, Revised September 1982 American Red Cross.

D. Statement of Understanding Between the Federal Emergency Management Agency and the American National Red Cross, January 22, 1982.

E. Available resources are listed in the National Directory of National Voluntary Organizations Active in Disaster (NVOAD), National Voluntary Organizations Active in Disaster, Disaster Operations, American Red Cross, 17th and D Streets, NW, Washington, DC 20006.

F. SLG-100 Guide for Increasing Local Government Civil Defense Readiness During Periods of International Crisis, Federal Emergency Management Agency.

G. Kentucky Health Facilities, Health Services, Major Medical Equipment, and Need Projections, updated several times a year, Commission for Health Economics Control in Kentucky, Cabinet for Health Services.

VII. APPENDICES

A. M-1 National Disaster Medical System

B. M-2 Military Casualty Reception

C. M-3 Mass Fatalities

D. M-4 Emergency Medical Care

E. M-5 Effective Use of Helicopters in Medical Emergencies and Disasters

F. M-6 Disaster Mental Health Plan for Emergency Response

G. M-7 Psychological Effects of Disasters on Responders

H. M-8 Reserved for Future Use

I. M-9 CSEPP Medical Service

J. M-10 Strategic National Stockpile (SNS) Program

K. M-11 CHEMPACK Usage

APPENDIX M-1
NATIONAL DISASTER MEDICAL SYSTEM (NDMS)

I. SITUATION AND ASSUMPTIONS

A. The National Disaster Medical System (NDMS) is a cooperative effort of the Department of Health and Human Services (HHS), the Department of Defense (DOD), the Department of Veterans Affairs (VA), the Federal Emergency Management Agency (FEMA), and the state and local governments and the private sector.

B. The federal government established the National Disaster Medical System (NDMS) to provide medical car for victims of a natural or technological disaster if state and local resources are overwhelmed. A catastrophic disaster, such as an earthquake, an industrial disaster or a large number of military casualties from an overseas war might cause NDMS to be activated.

C. NDMS is not designed for effectively cope with nuclear war casualties because the number of injured would exceed its capabilities.

D. NDMS includes Disaster Medical Assistance Teams (DMATs) and Clearing Staging Units (CSUs) at the disaster site, evacuation site or receiving location, a medical evacuation system, and more than 100,000 committed non-federal acute care hospital beds in more that 1500 hospitals throughout the United States.

E. Activation of NDMS (also see Tab M-1-1).

1. In the event of a major disaster, the Governor may request federal assistance under the authority of the Disaster Relief Act of 1988, PL 100-707. The President can also make a declaration of a major disaster or emergency that allow NDMS to be activated.

2. In situations not involving a Presidential declaration, NDMS can be activated by the Assistant Secretary of Health, Department of Health and Human Services (DHHS). Upon request of the Governor or other authorized state officials (i.e. the Kentucky Emergency Management Director, the state health officer or the state emergency medical director), under authority provided by the Public Health Service Act.

3. In the event of a national security emergency, the Secretary of the Department of Defense (DOD) has the authority to activate NDMS.

F. NDMS can be activated if the military medical system is overwhelmed by casualties returning to the states for hospitalization in the event of a conventional overseas conflict involving American forces. Military casualties would be first distributed between DOD and Department of Veterans Affairs Hospitals, then among U. S. non-federal hospitals.

G. NDMS does not replace state and local planning efforts. It supplements and assists when state and local resources are overwhelmed.

H. The metropolitan areas of Louisville, Lexington and Northern Kentucky are selected to receive casualties.

I. Directors of the Veteran's Administration Hospitals in Lexington and Louisville are the coordinators of NDMS for most of Kentucky. Northern Kentucky is coordinated through Wright-Patterson Air Force Base in Dayton, Ohio. A deputy coordinator at St. Luke Hospital in Covington coordinates for Cincinnati and Northern Kentucky.

II. MISSION

To provide medical support to state and local governments when the number of casualties resulting from a natural or technological disaster exceeds their capabilities and provide medical support if a conventional war overwhelms available health resources.

III. DIRECTION AND CONTROL

A. The NDMS Senior Policy Group (SPG) determines overall policy and program goals for NDMA and other aspects of health and medical preparedness, under the guidance of the National Security Council (NSC) and Domestic Policy Council (DPC). The SPG is chaired by the Assistant Secretary for Health, HHS, and includes the Assistant Secretary of Defense (Health Affairs), the Director of the Federal Emergency Management Agency, and the Secretary of Veterans Affairs.

B. Upon system activation, the NDMS Operations Support Center (NDMSOSC) will become operational to coordinate federal health and medical responses to the disaster.

1. The NDMSOSC roster includes representatives of HHS/Public Health Services, DOD, FEMA, VA, the American Red Cross, and other federal and private agencies concerned with medical services and medical logistics.

2. The NDMSOSC will work in cooperation with the Federal Catastrophic Disaster Response Group (CDRG), state emergency medical authorities, and the Federal Coordinating Officer (FCO) responsible for overall management of federal response to the disaster.

C. The Department for Health and Human Services is responsible for development of the national level plan.

D. Policy guidance and federal coordination will be provided by the Federal Emergency Management Agency (FEMA).

E. The state will coordinate its activities with those of appropriate federal agencies.

IV. CONCEPT OF OPERATIONS

A. The Governor can request activation of NDMS under the authority of the Disaster Relief Act of 1988, PL 100-707. Under authority provided by the Public Health Service Act, other authorized state officials (i.e. the Kentucky Emergency Management Director) can also request the Assistant Secretary for Health, HHS, to activate NDMS in situations not involving a Presidential declaration.

B. The Assistant Secretary for Health, HHS, will be responsible for the overall coordination of federal operations to assist state and local efforts in providing emergency medical care. The federal response will be provided through activation of the National Disaster Medical System (NDMS) at DHHS Headquarters in Rockville, Maryland. As part of the NDMS, HHS will carry out the following.

1. Operate the National Disaster Medical System Operations Support Center (NDMSOSC).

2. Assess the medical situation within the disaster area.

3. Provide guidance to the state.

4. Mobilize and dispatch medical assistance teams to the disaster area.

5. Activate NDMS hospital and transport elements to move excess patients to unaffected areas for treatment.

6. Coordinate with state and local governments and participating hospitals to transport patients from the affected area to hospitals.

C. A NDMS Coordinating Center is a federal or non-federal institution that recruits and coordinates non-federal hospital participation and links hospitals with local transportation, communications and other resources. There are 75 NDMS Coordinating Centers in the United States.

1. The Center will coordinate the arrival of patients from the disaster area.

2. The Kentucky Health and Family Services Cabinet (H&FSC), KyEM and local EM, in cooperation with the involved hospitals, will mobilize local emergency medical resources including transportation, communications, volunteers and facilities.

3. In conjunction with local facilities, organizations and governmental jurisdictions, the Coordinating Center will establish policies and procedures for receiving, sorting and transporting medical evacuees to facilities in the

designated metropolitan areas.

D. The State Emergency Medical Care Coordinator will collaborate with the Federal Emergency Medical Coordinator and direct the following six major functions.

1. Initial care and stabilization.

2. Assessment of numbers of casualties.

3. Coordination of incoming medical assistance.

4. Intra-regional evacuation and sorting of patients.

5. Preparation of casualties for evacuation from the region.

6. Transportation of patients to aero medical evacuation sites.

E. In Patient Evacuation, state and federal officials will coordinate the movement of patients to hospitals outside of the disaster area. In general, the following guidelines will be observed.

1. Casualties will be treated at a medical facility within their own community, county, or state, when feasible.

2. Patient condition and bed availability will be the main governing criteria for choosing hospitals.

F. Federal Medical Assistance to the disaster site will consist of Disaster Medical Assistance Teams (DMAT) and Clearing Staging Units (CSU) that are trained, skilled, equipped, and capable of mobilization and deployment within a few hours.

1. A DMAT is a 30-person unit composed of volunteer physicians, nurses, technical staff and other health professionals such as support staff, litter bearers and food preparation personnel.

2. When a DMAT is dispatched to a disaster site, it brings medical supplies and equipment, food, water and other necessary supplies.

3. A DMAT provides austere medical care, including triage and stabilization in a disaster area and at patient evacuation and reception sites.

4. The staff of a DMAT is trained to respond to a disaster as an organized team. Hospitals, volunteer agencies or health and medical organizations participating can form DMATs from interested professional and paraprofessional personnel.

5. A CSU can be formed from three DMATs, plus command and logistic support personnel. The CSU, because of its larger size and enhanced command and support staff, provides increased capability and self-sufficiency for assisting in large-scale operations over a longer period of time.

G. All non-military personnel being returned to the United States from overseas under NDMS will have to be cleared through customs and immigration. See Annex Z, Repatriation.

V. ADMINISTRATIVE SUPPORT

A. Principal administrative support functions are finance, transportation, communications, supplies and equipment.

1. NDMS hospitals, physicians and other providers of care and services will be reimbursed on the basis of billed charges.

2. Military and civilian aircraft will be utilized for transportation of casualties.

3. Most durable equipment is drawn from available surplus and excess items from government and non-government sources. Consumable medical supplies from federal depots will be ordered and shipped to disaster areas upon system activation, minimizing storage and perish ability problems.

4. Communications arrangements will use federal and non-federal resources.

B. Each federal, state and local governmental agency will provide its own administrative support.

C. The Commonwealth or local government is responsible for selecting the sites for casualty clearing/staging and insuring the necessary utilities and other support resources are made available.

VI. GUIDANCE PUBLICATIONS

A. National Disaster Medical System Design, July 13, 1983.

B. “Facts on the National Disaster Medical System”, June, 1990, NDMS, 5600 Fishers Lane, Rockville, Maryland 20857.

C. SLG-100/May 1990 Guide for Increasing Local Government Civil Defense Readiness During Periods of International Crisis, Federal Emergency Management Agency.

VII. TABS

Tab M-1-1 How to Request Assistance from NDMS.

TAB M-1-1
HOW TO REQUEST ASSISTANCE FROM THE
NATIONAL DISASTER MEDICAL SYSTEM (NDMS)

I. SITUATION AND ASSUMPTIONS

A. In disasters and emergencies requiring federal health and medical assistance, activation of the NDMS may be requested by the governor or other authorized state officials (i.e. the KyEM Director, the state health officer or the state emergency medical director).

B. NDMS may also be activated by the Assistant Secretary for Health, HHS, upon the request of a state health officer in situations not involving a Presidential declaration, under the authority provided by the Public Health Service Act, Public Law 78-410.

II. MISSION

To outline how to request assistance from the National Disaster Medical System (NDMS).

III. DIRECTION AND CONTROL

A. All requests for NDMS activation will be made to the National Emergency Coordination Center (NECC) operated by the Federal Emergency Management Agency (FEMA), Washington, D.C. and staffed on a round the clock basis. The telephone number is (202) 898-6100.

B. The Secretary of Defense (DOD) will activate the system if NDMS is necessary to care for military casualties of overseas conventional conflicts.

C. All requests for NDMS assistance will immediately be transmitted to an NDMS Duty Officer, who will take action to validate the request and arrange for activation of the appropriate elements of the NDMS.

1. Confirmation of the activation of NDMS will be made by telephone to the requesting official or their designee. Instructions regarding direct communications with the National Disaster Medical System Operations Support Center (NDMSOSC) will be provided at the time of confirmation of NDMS activation.

IV. CONCEPT OF OPERATIONS

A. Officials requesting NDMS assistance should be prepared to furnish the following information as part of an initial request for system activation.

1. Name, title, agency, telephone number and alternate telephone number of the requesting official.

2. Name, title, agency and telephone number of the alternate requesting official to be contacted for verification and response to the request.

3. The location of the incident for which assistance is being requested.

4. A brief description of the assistance requested, i.e. medical assistance teams, medical supplies/equipment, aero medical evacuation or acute hospital care.

APPENDIX M-2
MILITARY CASUALTY RECEPTION

I. SITUATION AND ASSUMPTIONS

A. PL. 97-174 assigns the responsibility for military casualty reception to the Department of Veterans Affairs. If the law is invoked, there may be situations in which the state plays a role. There may also be situations in which this law is not invoked yet the state will be called upon to assist in the reception/care of military casualties.

B. In the event of a large-scale conventional war, the number of casualties could exceed the available bed space in Department of Defense and Department of Veterans Affairs' hospitals. At this time, a decision at the national level would be made to activate the National Disaster Medical System (NDMS).

C. When NDMS is activated, military casualties will then be directed to civilian hospitals.

D. The hospitals in each NDMS area have agreed to receive these battlefield casualties who will arrive by aircraft at area airports for transportation to hospitals.

E. Aircraft carrying wounded will be routed to airfields in NDMS areas. All regulation of aircraft carrying casualties will be through the Armed Services Medical Regulating Office using NDMS area airports.

F. Ft. Campbell, Louisville, Lexington, and the Greater Cincinnati/Northern Kentucky airports have been designated as points of entry for military casualties arriving from overseas.

G. There will be a demand for acute care beds as well as non-acute care beds, such as skilled care, intermediate care and rehabilitation beds and for mental health counseling services when this annex is implemented.

II. MISSION

The mission of Military Casualty Reception is to coordinate movement of military patients from the designated airports to the receiving hospitals.

III. COMMAND AND CONTROL

NDMS, KyEM and local EM will maintain joint coordination.

IV. CONCEPT OF OPERATIONS

A. All coordination of a scene activity concerning the receipt of military casualties will be performed using the National Incident Command System (NIMS).

B. The allocation of beds for military patients is a voluntary procedure of the hospitals that participate in the program and will be coordinated by the Federal Coordinating Centers in each NDMS area (See Appendix M-1, National Disaster Medical System).

1. The Coordinating Center is either a federal hospital or a local EMS agency.

2. The functions of the Coordinating Centers are:

a. Recruiting and maintaining local non-federal hospital participation in the NDMS.

b. Assisting sponsors of Disaster Medical Assistance Teams (DMAT) and Clearing-Staging Units (CSU), participating hospitals and other local authorities in developing patient reception, transportation and communication plans prior to disasters.

c. During NDMS activation, coordinating the reception and transfer of patients coming into the area.

C. The Health and Family Services Cabinet (H&FSC) and the Transportation Cabinet will cooperate with the NDMS Coordinator in providing the necessary vehicles to move the patients from the airport to the designated hospitals.

D. The H&FSC will coordinate with the local NDMS Coordinators to insure adequate health personnel are available at the airport during triage and transportation to the hospital.

E. KyEM will coordinate the Commonwealth's response with the surrounding states.

F. Kentucky State Police will coordinate with the local law enforcement agencies and the designated airfield for security and traffic control problems.

G. The Department of Agriculture will insure that no foreign agricultural products are brought into the Commonwealth by the aircraft or its passengers.

H. Federal assistance will be provided under ESF #8 “Public Health and Medical Service” as set forth in the National Response Plan.

V. ADMINISTRATIVE SUPPORT

Each federal, state and local agency shall provide its own administrative support.

APPENDIX M-3
MASS FATALITIES

I. SITUATION AND ASSUMPTIONS

A. Incidents that produce mass fatalities place a special burden on a local jurisdiction. This creates the need for an emergency morgue, often requiring the work of specialists in identifying the victims, particularly those of fires or plane crashes. The actual process of identifying the victims in such cases can be lengthy and painstaking work. It might take several days to identify all of the deceased.

B. Most local jurisdictions are not equipped to handle such an operation and would experience difficulties in coping with the disaster. Standard Operating Procedures should be developed identifying suitable facilities, staff, and materials/supplies necessary for successful operation of an emergency morgue.

C. Emergency responders must take special care to avoid destroying evidence that could be used to identify victims or for legal proceedings.

D. At the request of the county coroner, the Kentucky Medical Examiner's office is directly involved in any mass fatality incident in a support capacity.

E. Local jurisdictions have identified emergency morgue sites in their counties.

II. MISSION

A. The mission of mass fatality planning and operations is to identify the facility, staff, and materials necessary for emergency morgue operations.

B. The mission of the county coroner is to recover and protect all bodies, to establish identity of victims and cause of death, to preserve all property found on or adjacent to the bodies and to maintain legal evidence for criminal or civil court action. A mass fatality investigation is generally conducted the same way as any death scene investigation, it just involves more victims.

III. DIRECTION AND CONTROL

A. According to Kentucky Revised Statutes 72.400, after the sick and injured are removed from the disaster site, the county coroner is in charge of the site until the deceased and accompanying evidence are removed. The coroner coordinates all operations pertaining to this process.

B. Security must be established and maintained at the disaster site. Admission to the disaster area should be restricted to authorize personnel.

C. The establishment and operation of an emergency morgue is under the direction and control of the local coroner. If the determination is made that the number of victims is far greater than the local capacity, the emergency morgue should be opened.

D. Medical, administrative and law enforcement personnel from the local jurisdiction, if available will staff the emergency morgue. Further assistance may be obtained from the Kentucky Medical Examiner's office, FBI Disaster Squads, the Kentucky Funeral Directors' Associations' disaster team and the National Funeral Directors' Association. The number of victims and available staff will determine morgue hours.

E. No local jurisdiction can be expected to purchase and store the necessary supplies to operate an emergency morgue. It may be necessary for the state to assist in locating, purchasing and transporting these supplies.

IV. CONCEPT OF OPERATIONS

A. All mass fatality incidents will be managed using the National Incident Management System (NIMS)

B. Deceased will be left in place until an adequate death scene investigation can be conducted and the coroner states they may be moved.

C. The emergency morgue will be operated under the control of the local coroner.

D. If the mass fatalities are the result of a catastrophic disaster (major earthquake or nuclear war) that prevents individual interment, bodies will be buried in mass graves. During such a burial, records must be kept of the person buried and their position in the grave.

E. Under no circumstances should attempts be made to get rid of bodies by burning.

F. At the direction of the coroner, bodies will be transferred from the disaster site to the temporary morgue where they will be positively identified. Bodies are usually not released by the coroner until all have been identified.

G. The county will provide utilities, security, communications, refrigeration, sanitation, and other supplies and equipment needed to operate the morgue.

H. Once notified, the Kentucky Medical Examiner's office will determine the level of assistance required and notify those trained specialists needed to assist in working the disaster, both at the disaster scene and the temporary morgue. They will also identify supplies needed and coordinate the transportation of these supplies.

I. Post-mortem examinations will be conducted on all of the deceased; other appropriate tests will be conducted when necessary.

J. Positive identification of the bodies will be conducted by the coroner and will be based upon medical and dental records and the detailed information about each individual provided by family members. Although viewing of bodies by family members is usually not required for positive identification, a viewing area can be

established at the morgue.

K. Unless the temporary morgue is established at a large facility, specially trained professionals at a location near the morgue should offer grief and crisis counseling.

L. Counseling for family members is helpful just prior to viewing the deceased; clergy or counselors can accompany the family.

M. Federal assistance when provided will be coordinated under ESF #8 “Public Health and Medical Services of the National Response Plan. Under this ESF the federal government can activate a Disaster Mortuary Team (DMORT) to assist in body identification.

V. ADMINISTRATIVE SUPPORT

The County in which the incident happens will, if possible, provide administrative support. The Medical Examiner will provide forms and documentation and supplementary administrative support.

VI. REFERENCE DOCUMENTS

Kentucky Coroners Mass Fatality Situation Handbook, Kentucky Justice Cabinet Department of Criminal Justice Training and the Kentucky Medical Examiner's Office, October, 1990.

Coroner Services Annex of California Office of Emergency Services' Earthquake Response Plan: Southern San Andreas, 1983.

VII. TABS

Tab M-3-1 Checklist for Developing a Temporary Morgue

Tab M-3-2 Equipment Needed to Operate a Temporary Morgue

TAB M-3-1
CHECKLIST FOR DEVELOPING A TEMPORARY MORGUE

1. Temporary morgue facilities should be located as close to the disaster site as possible. Facilities that can be used as temporary morgues include: National Guard Armories or tents; factories; fire stations or rescue service buildings; state or county maintenance garages and airplane hangars. Schools and churches can be used but the other facilities are preferred.

2. The facility should have electricity, hot and cold water, rest rooms, air conditioning/heating and/or good ventilation, sufficient space, parking areas, space to park refrigerated trucks adjacent to the facility, communications capabilities, security (preferably surrounded by a fence and removed from the public view), space for a canteen and rest area, and cement floors and floor drains, if possible.

3. The morgue facility should have room for all essential operations on one floor and should either not have any stairs or should have ramps. If the facility is a large, open space; it must be possible to erect partitions to separate various work areas (fingerprinting, dental, autopsy, funeral preparation, etc.) to lessen the impact on those working within the morgue. Work areas should not be visible to members of the general public or the bereaved.

4. Essential operations at the morgue include but are not limited to: dental charting, x-ray, toxicology, fingerprinting, documentation of personal effects and identifying characteristics of the deceased, autopsies (unless they are performed at a local morgue), embalming, a records area, a secured area for personal effects and identifying characteristics of the deceased, autopsies (unless they are performed at a local morgue), embalming, a records area, a secured area for personal effects of the deceased, space for typists, clerks and vital statistics personnel and a phone bank for gathering information and handling inquiries.

5. Most deceased are identified through fingerprints, dental or medical records or distinguishing characteristics, but an area where relatives can view bodies for identification may be established. Closed circuit television or videotape can also be used.

6. If the morgue is established at a large facility, space for the media, a room for interviewing individuals seeking missing persons, room for the clergy and grief/crisis counseling can be established there; otherwise, they should be located at nearby buildings with amenities, such as telephones, rest rooms and a canteen.

7. Law enforcement personnel will be needed to control access to the morgue and the central location where the families will congregate. All entrances to the morgue must be secured and attended at all times to limit access. Having law enforcement personnel answer the telephone at the morgue reduces the

number of unnecessary calls.

8. Arrangements should be made for specially trained professionals to provide grief and crisis counseling. If located in a large facility, this counseling can be provided at the morgue. Otherwise, it should be provided at a nearby location. If possible, this area should provide some privacy. Clergy or counselors who have received grief training can accompany relatives called upon to identify bodies.

9. Having a dental forensic computer system and establishing access to major dental computer systems, such as federal and the military, will greatly speed up the operation.

10. If the refrigerated trucks are used for holding remains, the commercial logos on the trucks should be covered by a tarp. In most cases, the maximum number of bodies per truck is 15.

11. A washer and dryer may be required for laundering clothing before displaying it for identification purposes.

TAB M-3-2
EQUIPMENT NEEDED TO OPERATE TEMPORARY MORGUE

I. SITUATION AND ASSUMPTIONS

A. Equipment needed for temporary morgue

1. Stretchers, wheeled
2. Stretchers, army type with wooden handles
3. Shrouds, opaque plastic
4. Sheets
5. X-ray machine, portable with necessary supplies and power cord
6. Paper, brown, craft
7. Tape, masking
8. Tape, cellophane
9. Bags, plastic and paper
10. Tags, identification with strong cord or wire attached
11. Stationery supplies
    a. paper
    b. pens
    c. pencils
    d. stapler
    e. paper clips
    f. cardboard
    g. string
12. Bag, human remains
13. Buckets
14. Mops
15. Disinfectant, concentrated
16. Tables
17. Chairs
18. Soap, hand
19. Towels, paper
20. Gloves, surgical, rubber
21. Aprons, plastic
22. Gowns, surgical
23. Masks, surgical
24. Respirators
25. Stanchions (for holding signs)
26. Rope (for barricading areas, walkways, etc.)
27. Insect spray
28. Air freshener
29. Extension cords
30. Adapters, electric cord
31. Lamp, extension gooseneck
32. Wooden stakes
33. Portable generator
34. Portable lights

35. Refrigerated trucks
36. Telephones (if it is available, the State Police have a van equipped with telephones and other communications equipment that the Kentucky Medical Examiner's Office can use in mass fatality incidents.)
37. A phone number for families to call to help identify the deceased. Before the phone number is released, multiple copies should be made of a questionnaire to use in interviewing the callers. One can be found in the county coroner's copy of the Kentucky Coroner's Mass Fatality Situation Handbook.
38. Status boards
39. Plywood
40. Cameras (with plenty of film)

B. Disaster Dental Identification Kits

1. Gowns
2. Scalpels
3. Seldon elevators
4. Hemostats
5. #6 explorers
6. #23 explorers
7. Cotton pliers
8. #17 scissors
9. Alcohol torch
10. Alcohol
11. Wire cutters
12. Mirrors w/handles
13. Shade guide and mold holders
14. Bowley gauge
15. Plastic cups
16. Tooth brushes
17. Adult mouth props
18. Teeth exam charts
19. Tongue depressors
20. Striker cast cutter saw
21. 2x2 gauze sponges
22. 4x4 gauze sponges
23. Bandage scissors
24. 2" adhesive tape
25. Surgical masks
26. Rubber gloves
27. Surgical gloves
28. Face masks
29. Scalpels
30. Extension cords
31. Examining lights, gooseneck
32. Flashlights, BR22
33. Batteries, "D"
34. Bulbs, PR 6

35. Pencils
36. Ball point pens
37. Marking pencils, grease, black

APPENDIX M-4
EMERGENCY MEDICAL CARE

I. SITUATION AND ASSUMPTIONS

A. Kentucky could experience a natural or manmade disaster of such magnitude that it would overwhelm the local or regional response capabilities. Earthquake, tornado, dam failure, hazardous materials accident, terrorist action, and war are among the hazards that have the potential of causing mass casualties beyond the scope of normal response.

B. Effective medical treatment for casualties of a major disaster must be available almost immediately and especially during the first 24 hours. An intensive effort will be required for the first two or three days following the disaster. This can be phased out as regular medical care providers are able to meet the needs.

C. The Commonwealth of Kentucky has developed a Medical Response Plan to manage the mass casualties of a natural or manmade disaster. It focuses on disasters that exceed local response capabilities and require the state's involvement.

D. In a major disaster, massive medical support will be required immediately to effectively treat casualties. The state Health and Family Services Cabinet (H&FSC) has established a network of 15 regional medical coordinators who are familiar with medical resources within and near their regions and can assist in providing medical personnel, equipment and supplies and in transporting casualties.

E. Assistance can also be requested from or provided to adjacent states. Assistance can be requested from the federal level if Kentucky's response capabilities are exceeded.

F. The National Disaster Medical System (NDMS) can be accessed if the casualty situation is beyond the state's capabilities.

G. Following a catastrophic disaster, the National Response Plan might be implemented to immediately assist state and local response efforts to save lives and protect property. Within that plan, one of the Emergency Support Functions (ESFs) is Health and Medical Services (ESF #8). This ESF provides for emergency medical services using the framework of NDMS. Services include triage, evacuation and medical treatment of victims, provision of supplemental nursing and medical supplies and personnel and assistance in responding to public health threats (water, sanitation, human and animal remains, disease control and environmental pollution). Upon activation of this plan, state and federal officials will work together in responding to the disaster.

H. Kentucky's Emergency Operations Plan (KyEOP) is designed to coordinate with NDMS and the Federal Response Plan.

I. Surge, an extraordinary increase in preparedness activities to meet an impending threat, is described in Section 19, "Actions to Increase Health Medical Readiness" of the Guide for Increasing Local Government Civil Defense Readiness During Periods of International Crisis. It outlines crisis actions which may be taken by local government health departments, supported by organizations of physicians and other health professionals, to increase readiness to deal with the health and medical problems which could be created by a nuclear attack on this country.

II. MISSION

The mission of Emergency Medical Care is to enable the Commonwealth of Kentucky to react immediately, maximize utilization of resources and effectively manage casualties resulting from a disaster happening either in Kentucky or an adjacent state. It is designed to be compatible with the National Disaster Medical System (NDMS) that can be implemented if the number of casualties exceeds state capabilities.

III. DIRECTION AND CONTROL

When the state Emergency Operations Center (EOC) is activated, the H&FSC sends one or more Agency Coordinators to coordinate response operations of the Cabinet. The H&FSC coordinator works with the county health and medical coordinators, Casualty Collection Site coordinators and regional medical coordinators.

IV. CONCEPT OF OPERATIONS

A. State Activities

1. All activities are coordinated using the National Incident Management System (NIMS).

2. Upon proclamation of an emergency by the Governor and activation of the EOC, designated individuals from the H&FSC coordinate health services from the state EOC/DFO.

3. The H&FSC Agency Coordinator primarily uses the teletype, fax and landline equipment for inter- and intra-state communications with emergency medical care system staff and resource suppliers, but could also use a radio installed in the state EOC/DFO to communicate with regional coordinators when the regional concept is implemented.

4. Coordination of transportation from the Casualty Evacuation Sites to the Casualty Receiving Sites is the responsibility of the H&FSC Agency Coordinator. Aircraft are the primary means of patient transport; buses and trucks can also be used.

5. The H&FSC Agency Coordinator coordinates transportation for supplies, equipment and medical personnel being transferred between states and

regions. Aircraft are the primary means of transport.

6. Regional coordinators and the H&FSC Agency Coordinator are responsible for coordinating re-supply of the First Aid Stations, Casualty Collection Sites, Casualty Evacuation Sites and Casualty Receiving Sites. Requests for supplies and equipment are processed through command channels. To assure accountability, periodic resource status reports are made through channels to the H&FSC Agency Coordinator.

B. Regional Activities

1. All activities are coordinated using the National Incident Management System (NIMS).

2. If the disaster overwhelms local resources, the network of regional medical coordinators could be activated.

3. Each regional medical plan identifies medical facilities, personnel, supplies, equipment, transportation, communication systems, casualty collection sites, casualty evacuation sites and casualty receiving sites. The purpose of casualty collection sites is to supplement hospital acute care; casualty evacuation sites and casualty receiving sites are established at airports to aid in patient transport.

4. In the area affected by the disaster, regional responsibilities include activation of casualty collection and evacuation sites, mobilization and transportation of medical supplies and equipment and transportation of victims within the region. The regional medical coordinator is responsible for providing the facilities at the casualty evacuation sites, which could include a surgical unit.

5. Regional medical coordinators outside the disaster area will activate casualty-receiving sites, coordinate with hospitals in their region that will receive casualties and manage the movement of casualties.

6. If the disaster is catastrophic and the National Disaster Medical System is activated, Disaster Medical Assistance Teams (DMATs) and Clearing Staging Units (CSUs - formed from three DMATS, plus command and logistic support personnel) could be used at Casualty Collection Sites and Casualty Evacuation Sites. (See Appendix M-1, Section IV, F.)

C. Local Activities

1. All activities are coordinated using the National Incident Management System (NIMS).

2. The county health and medical coordinator works with the county medical society, private organizations and governmental agencies to choose the number and locations of Casualty Collection Sites and First Aid Stations. The

coordinator is also responsible for identifying, obtaining and coordinating the utilization of personnel, supplies and equipment at the First Aid Stations, and initially at the Casualty Collection Sites, with the Regional Coordinator assuming responsibility for the ongoing supply of manpower and materials if response to the disaster exceeds local capabilities.

3. Locations of the Casualty Collection Sites are being identified and published in both the regional medical plan and the county EOP.

4. Activation of First Aid Stations, Casualty Collection Sites, Casualty Evacuation Sites and Casualty Receiving Sites will be totally dependent upon the magnitude of the disaster and the ability of the local medical community to meet the needs of the casualties. Each component should be activated only if needed to supplement existing resources.

D. First Aid Stations

1. At First Aid Stations, initial medical care may be provided by pre-identified persons who reside in the immediate vicinity. Depending upon their level of training, medical personnel may administer lifesaving procedures, such as resuscitation, control of heavy bleeding or treatment for shock to the seriously injured prior to transport to a Casualty Collection Site.

2. Most of the casualties will arrive on foot or in private vehicles. Some casualties will receive all necessary treatment there; others will be referred to the hospital or Casualty Collection Site and will be transported by private vehicles or ambulances.

3. If necessary, First Aid Stations should be established throughout the disaster area to supplement care received at regular treatment facilities.

   a. The First Aid Stations can be located in any safe facility or vehicle that provides a satisfactory degree of protection from the elements and is suitable for the storage of first aid supplies.

   b. Following a disaster, most people will first seek medical care at their family doctor's office or a hospital. These facilities could be heavily damaged following a major disaster, creating a need for alternative medical facilities.

E. Casualty Collection Sites

1. Casualty Collection Sites provide triage, treatment, counseling, transportation and tracking for seriously injured disaster victims. They are established when hospitals are overwhelmed by the number of casualties or when hospitals facilities are damaged in the disaster. Victims arrive on foot, in private and public vehicles, and in ambulances and helicopters. After being stabilized, victims may be transported via ambulance and helicopter to the nearest

Casualty Evacuation Site for further transport out of the disaster area.

2. Services to be provided at Casualty Collection Sites include:

   a. Resuscitation

   b. Controlling bleeding

   c. Wound care

   d. Treatment for shock

   e. Splinting fractures

   f. Treating burns

   g. Pain relief

   h. Fluid replacement

   i. Counseling

   j. Triage

      1) Triage, the classification and separation of victims depending on their severity of injury and treatment necessary, is a continuous process throughout the duration of the disaster but occurs in three distinct stages.

         a) Primary triage is tagging of victims at the scene.

         b) Secondary triage is sorting the victims at the Casualty Collection Site for priority of treatment.

         c) Setting of priorities for evacuation to and among hospitals.

      2) The three-level triage system for sorting victims according to their priority for emergency treatment and evacuation is:

         a) Life threatened -- critically injured, but will recover if treated immediately.

         b) Urgent -- seriously injured, may die without further treatment.

         c) Delayed -- non-critical injuries, dead or dying.

3. Since the emphasis at Casualty Collection Sites is on triage, resuscitation and stabilization, a full range of medical personnel from physicians to aides, must

be available at each of these sites. The mixture will vary with the size of the site, availability of medical personnel, and duration of the response.

4. The Casualty Collection Sites will also provide medical care for patients contaminated with hazardous/poisonous chemicals, etc. Life threatening injuries will be treated first, decontaminated later. See Annex Q for decontamination procedures.

5. Criteria for selecting a Casualty Collection Site

   a. Located on or near a major road network, and if possible, near a hospital.

   b. Easily assessable by land, water and air for victims, staff and suppliers.

   c. Adequate parking space for vehicles bringing victims, supplies, equipment and medical personnel.

   d. Space available for an ambulance holding area and a helicopter-landing site. (See Appendix M-5 for more detail.)

   e. The landing site should be pre-approved by the Kentucky Department of Military Affairs

   f. Shelter should be available that offers water, sanitation facilities, electricity and emergency power.

   g. Facilities that are adequate for treating several hundred people in a 24-hour period.

      1) Temporary shelter, such as tents, can be used in the patient service area.

      2) Adequate space must be available to erect temporary facilities and handle the air and land traffic accessing the site.

      3) Most schools meet the criteria; other possibilities include hospitals, churches and government buildings with large parking lots.

F. Casualty Evacuation Sites

1. If needed, Casualty Evacuation Sites are usually established at the major airport, rail and/or trucking terminal in the region. They are primarily transport points designed to provide the minimum medical services necessary to stabilize the victim awaiting transportation out of the disaster area.

2. If there is a need for a centrally located surgical center and the necessary personnel, supplies and equipment can be secured, one might be established

at the Casualty Evacuation Site.

a. Victims requiring immediate surgical intervention can be sent to this surgical facility before being transported to the Casualty Receiving Site or hospital.

b. Services available at the surgical facility can include:

1) Resuscitative surgery.

2) Pre- and post-operative intensive care.

3) Medical treatment necessary for further evacuation.

4) Laboratory, pharmacy and radiology services (limited).

5) Limited nursing care.

G. Casualty Receiving Sites

1. If needed, Casualty Receiving Sites are usually established at airports. They are transfer points that provide only limited treatment services, such as resuscitation, fluid replacement, dressing replacement and re-triage.

2. Victims will be off-loaded onto ambulances and transported to the nearest appropriate participating hospital for definitive treatment.

3. More personnel will be required to coordinate the patient receiving/dispatching functions than to provide medical services.

H. Blood Management

See Annex M, Section IV, C, 5 for details on Blood Management

I. Transportation

1. Primary means of transportation are military and civilian aircraft, commercial buses, trucks and ambulances.

2. When practical, vehicles used to transport victims should be utilized to transport necessary medical personnel, supplies and equipment back to the disaster area on their return trips.

3. Since blood must be kept refrigerated, some of the vehicles used to transport victims to the Casualty Evacuation Site or hospitals outside the disaster area should be equipped to transport blood to the disaster site. Major airports in each region will be the initial shipping/receiving points for blood.

J. Supplies and Equipment

1. While the emergency medical care system is in operation, a large amount of supplies and equipment will be requisitioned from locations throughout the state.

2. To adequately manage these resources and assure accountability, a formal requisition/inventory system must be implemented immediately upon activation of a medical service site. The person in charge of the site will appoint the inventory control officer.

V. GUIDANCE DOCUMENTS

Commonwealth of Kentucky – Medical Response Plan

SLG-100 Guide for Increasing Local Government Civil Defense Readiness During Periods of International Crisis, Federal Emergency Management Agency

VI. TABS

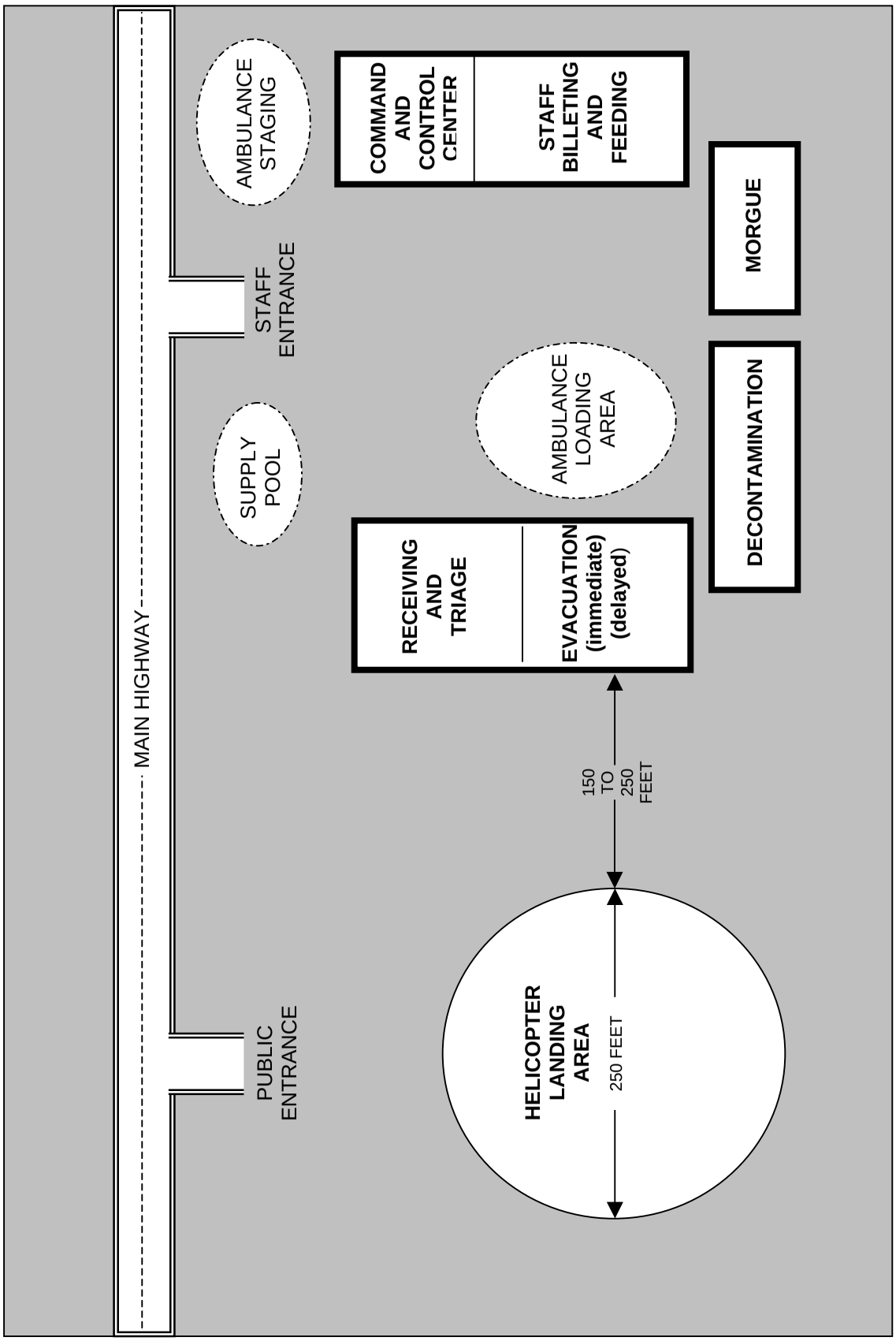
A. M-4-1 Medical Response Chart

B. M-4-2 Suggested Casualty Collection Site Layout

C. M-4-3 Sample Triage Tag

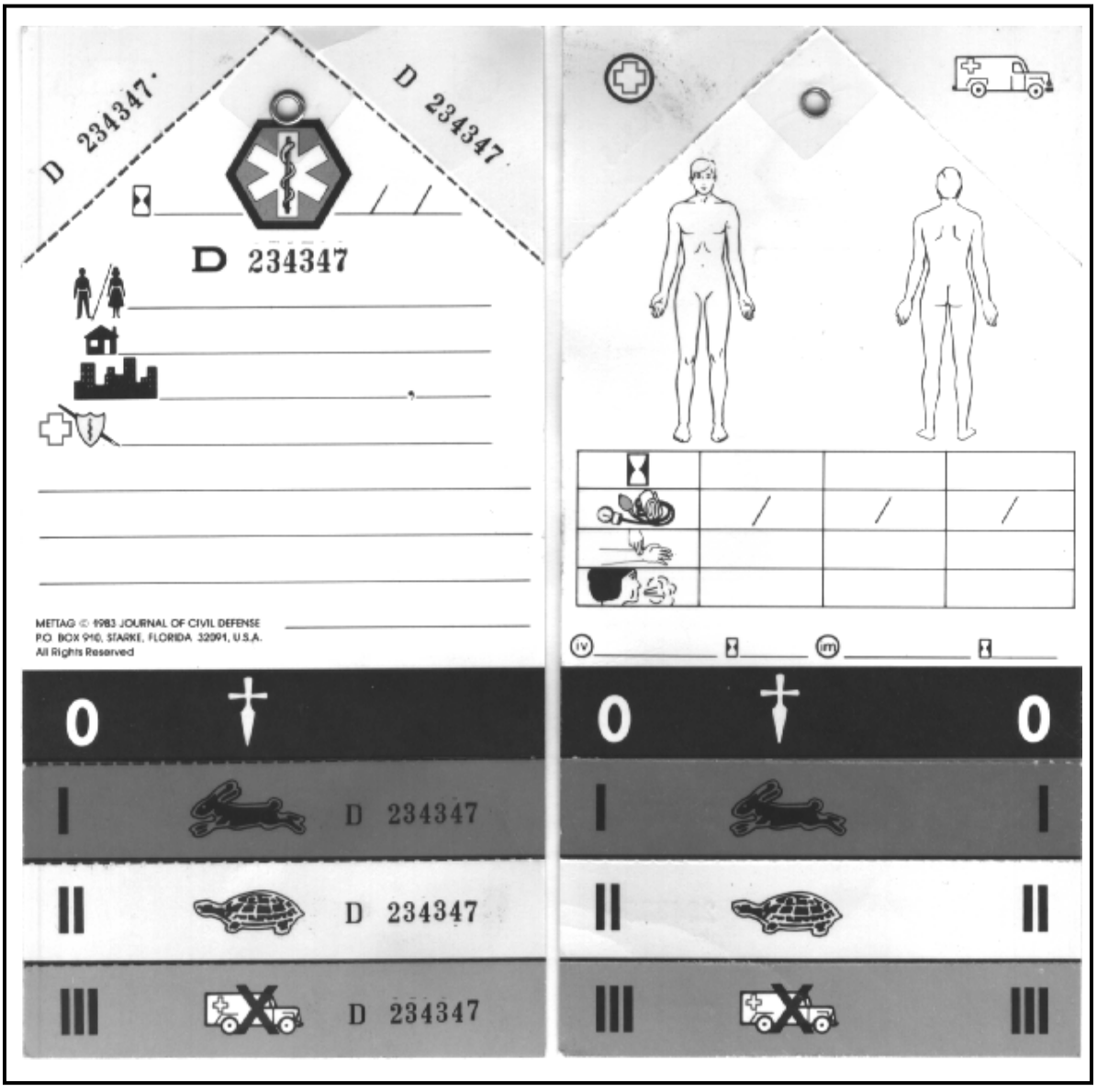
ACTIVITY	DISASTER AREA			OUTSIDE REGIONS		STATE
FACILITY	**AID STATION**	**CASUALTY COLLECTION SITE**	**CASUALTY EVACUATION SITE**	**CASUALTY RECEIVING SITE**	**HOSPITAL**	**EMERGENCY OPERATIONS CENTER**
TRANSPORTATION	Manual Means, Walk, Private Auto and Public Transportation	Helicopters, Ambulances, Buses/Trucks	Long Range Aircraft	Ambulance		Coordinates Transportation Between Regions
SERVICE	Field First Aid	Triage-Stabilize	Supportive Care Surgical Care	Limited Care	Definitive Care	Command and Control
COMMAND	Local Agencies	County Medical Coordinator	Regional Medical Coordinator	Regional Medical Coordinattor	Hospital Administrator	State Medical Coordiantor
MEDICAL PERSONNEL	Available Personnel	Predesignated Local Medical Personnel Supplementd by Regional and State Personnel	Regional Evacuation Team and Mash Units	Regional ReceivingTeam	Hospital Staff	Coordinate Transfer of Personnel, Region to Region
SUPPLIES AND EQUIPMENT	Local	Local, Regional and State	Regional and State	Regional and State	Supplemented by State and Federal as Needed	Coordinate Transfer of Medical Resources, Region to Region

TAB M-4-2
SUGGESTED CASUALTY COLLECTION SITE LAYOUT



TAB M-4-3
TRIAGE TAG

The TRIAGE TAG shown is the TRIAGE TAG of preference to use in marking patients. If this TAG is not available use color codes shown on page M-4-3-2.



When color cards are not available, the color should be written on tape and placed on the victim's forehead if possible, otherwise wrap around the wrist, or place on another visible part of the body. The international medical color code is as follows:

Red Color: Critical condition patients. They require immediate and intensive medical care due to imminent risk to their lives, like in cases of airway injuries by obstruction, pnemonothorax, unstable thorax, hypovolhaemic shock by intra-abdominal hemorrhage and vascularly injured wounds. They are patients whose prognosis, if appropriately and early attended, is favorable: their over life rate is very high. First priority is assigned to these patients.

Yellow color: Severe condition patients. This group is formed by grave patients whose prognosis is better due to injuries which can wait a reasonable time to be attended without changing the over life possibilities, like patients with multiple or open fractures, uncomplicated cranioenephalic traumatism. Second priority is assigned to these patients.

Green color: This color identifies very critical patients and slightly injured patients. It includes, therefore, two types of patients: those whose prognosis is bad due to the type of injuries, even in the best circumstances, like skull traumatism with exposed encephalic mass and extensive thorax injuries, where the most important thing is maybe to mitigate the pain, and slightly injured patients which can be attended as out-patients. Third priority is assigned to these patients.

Black color: Corpses. They must be treated respectfully. A priority is not assigned, but they must be transferred to morgues, without using the ambulances to this end.

APPENDIX M-5
EFFECTIVE USE OF HELICOPTERS IN MEDICAL EMERGENCIES AND DISASTERS

I. SITUATION AND ASSUMPTIONS

A. Helicopters can be extremely useful in mass casualty incidents. Helicopters have the potential of saving victims and reducing transport time for patients, medical personnel and equipment. Lives are often saved that would be lost if helicopters were not available. However, for some incidents, ground transportation is preferable and for others, helicopters can have a negative effect on operations.

B. The helicopter's ability to land and take off in an area only slightly larger than the helicopter itself, its ability to hover while picking up or discharging cargo and passengers and its ability to carry cargo or heavy equipment slung externally beneath then drop it off without having to land are three of its advantages over other forms of transportation.

II. MISSION

To use helicopters appropriately and effectively in saving lives. In disaster preparedness planning, helicopters are highly effective, but should be considered as an alternate rather than primary means of patient transport.

III. DIRECTION AND CONTROL

A. When choosing a Helicopter Landing Zone (LZ), appropriate officials should choose a site that meets the helicopter's safety requirements.

B. To ensure the safe operation of helicopters to and from temporary LZs, according to Rotorcraft Use in Disaster Relief and Mass Casualty Incidents – Case Studies, "the establishment and operation of the LZs should be the specific responsibility of an assigned individual with knowledge of helicopter requirements and capabilities. That person should be able to communicate with the helicopter, the Incident Commander, landing zone controllers, medical facilities and other destinations, and have the authority to make decisions and issue orders regarding aircraft utilization and safety without prior consultation".

IV. CONCEPT OF OPERATIONS

A. Situations in which a helicopter cannot or should not be used and cautionary notes:

1. If weather conditions are unfavorable or a safe landing zone cannot be provided, ground transportation should be utilized to avoid unnecessary risks for the helicopter crew, emergency responders, and victims.

2. If there is widespread loss of electric power, the helicopter pilot will lose familiar reference points of lighted landmarks and warning lights on tall buildings.

3. Helicopters might not be available immediately following a tornado due to the uncertainty of weather conditions.

4. Military helicopters frequently have fewer communications options than civilian helicopters and ground-based responders. This could result in a communications gap. Civilian EMS helicopters are better equipped to support victims during transport; so military helicopters should be used to transport the less seriously injured. Civil authorities who are unfamiliar with flight characteristics an dimensions of military helicopters might have difficulties ensuring them a safe LZ.

5. The LZ must meet a specific helicopter's size requirements, should be free of overhead obstructions and should be level. The LZ can be a quite dangerous place so it must be set up and managed by someone who is familiar with safety rules of a helicopter LZ.

6. Helicopter search and rescue requires special training and special equipment. EMS helicopters usually do not participate in search and rescue operations.

7. When incident occurs in close proximity to a medical center and the roads are passable, ground ambulances can transport casualties almost as rapidly as helicopters.

8. Incidents involving radioactive materials, explosives, poisonous gases/vapors, and chemicals in danger of exploding and burning pose special dangers to the crew of a helicopter.

    a. The LZ must be upwind, at least one-quarter mile from the site of a hazardous materials accident involving radioactive materials.

    b. The LZ must be upwind, at least one mile from the site of a hazardous materials accident involving toxic gases or vapors or radioactive gases (steam or smoke).

    c. If a hazardous materials accident produces toxic gases or vapors, the LZ must never be located in low-lying area because heavier-than-air gases will gather there.

    d. Victims contaminated by hazardous materials cannot be transported by helicopter unless they have been decontaminated or other measures have been taken to protect the crew because the confined space of the helicopter could cause the crew to be overcome by the hazardous chemical.

B. Situations in which a helicopter is an asset.

1. When time or distance would jeopardize a patient's chance of survival, EMS helicopters are exceptionally valuable.

2. In a high rise fire situation, helicopters can be used to transport needed gear from distant locations, resupply fresh SCBA air bottles, airlift firemen and equipment to the roof and evacuate victims, and injured or exhausted firemen from the roof and remove bodies after the fire is under control.

3. Helicopters can be used to rescue survivors of a wintertime crash in icy waters and search for victims on or under the ice. They can also be used to rescue victims from swiftly flowing floodwaters or from collapsed sections of bridges.

4. Helicopters can quickly transport trained search dogs and their handlers to remote areas or to collapsed structure sites.

5. Following a major earthquake, it might take days or weeks to complete safety inspections and repair damage to highways, railroads and docking facilities. Airports should remain at least partially functional. Helicopters might be the best available means for transporting casualties, specialized personnel and essential supplies and equipment.

6. Transporting medical personnel by helicopter to the scene of a mass casualty incident in a remote location may decrease the time required for triage and stabilization of casualties prior to transport.

V. GUIDANCE DOCUMENTS

A. Rotorcraft Use in Disaster Relief and Mass Casualty Incidents – Case Studies, Final Report, June 1990, Federal Aviation Administration. Local officials can obtain a copy of this document, DOT/FAA/RD-90/10 from the National Technical Information Service, Springfield, VA 22161.

B. University of Kentucky Hospital Aeromedical Service Procedure Manual, University of Kentucky Hospital 800 Rose St., Lexington, KY. 40536.

C. Saint Joseph Hospital HealthNet IV Aeromedical Services pamphlet. Address: One Saint Joseph Dr., Lexington, KY 40504.

D. Heliport Design, Advisory Circular, January 4, 1988, Publication number: 150/5390-2, Federal Aviation Administration, 800 Independence Ave., S.W., Washington, D.C. 20591.

E. "LZ: Preparing a Landing Zone," edited by Jim Whitman, revised June, 1987, National EMS Pilots Association, PO Box 2354, Pearland, TX 77588.

VI. TABS

M-5-1 TIKI-MAST

TAB M-5-1
TIKI-MAST

I. MAST

A. The MAST (Military Assistance to Safety and Traffic) is an interagency effort among the Federal Departments of Transportation (DOT), Health and Human Services (HHS), and Defense (DOD), which provides assistance to the civilian community.

B. DOD personnel, equipment and supplies are kept in a continuous state of readiness so they can respond efficiently and effectively to serious medical emergencies, which are defined as situations in which a person's perceived condition requires air transportation to a medical care center as quickly as possible to prevent death or aggravation of an illness or injury, and in which an alternative means of transportation is not adequate.

C. MAST can only be called upon if civilian EMS air or ground ambulances are unable to respond or if their capability is exceeded.

D. Emergencies for which MAST is used include: evacuation of accident victims, inter-hospital transfer of patients or key medical personnel or transfer of blood or human organs.

E. MAST requests can be initiated by hospital officials, law enforcement officers, or other responsible persons. Civilian physicians requesting air ambulance transportation for inter-hospital transfers are responsible for providing a civilian medical attendant to accompany evacuees en route. MAST is not responsible for returning civilian medical attendants to initiating hospitals.

F. MAST provides the following to designated civilian communities:

1. Air ambulances/air rescue-type helicopters.

2. Air ambulance/air rescue-type crews.

3. Medical personnel.

4. Medical equipment.

G. MAST may not be available when called because Air MEDEVAC priorities are as follows:

1. Combat readiness flying.

2. Field exercises/installation support.

3. MAST.

H. The Pilot-in-Command (PIC) has the authority to cancel missions for two reasons:

1. Weather.

2. In the case of patient transfers, if there is no civilian medical attendant to accompany the patient en route.

I. MAST is available within a 100 nautical mile radius of participating military installations, such as Ft. Campbell and Ft. Knox. Approval for missions outside that radius can be approved under the following conditions:

1. Death or disablement of the patient is inevitable unless a MAST helicopter is used.

2. MAST helicopter is the only available means of transportation, considering the seriousness of the patient's condition and accessibility of the patient by surface personnel or vehicles.

J. Next-of-kin may be allowed to accompany the patient when it is in the best interest of the patient. Normally only one next-of-kin will be allowed.

K. Special equipment, such as a portable incubator or defibrillator, may be required for the safe evacuation of a particular patient. For such cases, the donating hospital is responsible for providing this equipment. The MAST crew will not be the responsible agency for returning special equipment; however, the Pilot-in-Command may assist the accompanying civilian medical attendant in returning those items, depending upon availability of flight time and other technical considerations.

L. Military commitments, such as the Gulf War in 1991 and 2003, take precedence over MAST services to the civilian population. When this situation occurs, the military notifies appropriate civilian officials in writing that the MAST program will be suspended and lists the inclusive dates of the suspension.

II. TIKI-MAST

TIKI-MAST (Tennessee/Indiana/Kentucky/Illinois and the eastern edge of Missouri) is available for areas within a 100-mile radius of Ft. Campbell. It does not normally go outside that radius because a closer ambulance service could get there faster and provision would have to be made for refueling if it were used beyond that limit.

A. Capabilities and Limitations

1. The 50th Medical Air Ambulance Company can provide 24-hours per day emergency transport, seven days per week.

2. The MAST unit maintains UH-60 helicopter and crew on 24-hour alert to respond to emergencies.

3. Response Time. Pre-flight preparation prior to lift-off normally takes 15-20 minutes. For missions involving special equipment or procedures, reaction time is lengthened. Flying time which varies according to distance adds another 20-45 minutes, making an average response time of 40-60 minutes.

4. Weather. Adverse weather conditions, such as thunderstorms, icing, or ground fog may prevent safe flight operations. The Pilot-in-Command (PIC) has the authority to cancel the mission due to weather.

5. The military air ambulance helicopter has a capability to transport up to four litter and one ambulatory patient in addition to a crew of four. Standard medical equipment carried includes oxygen, suction, and bag-mask equipment and backboards, blankets and an assortment of bandages. Special equipment includes a converter for hook-up of medical equipment to aircraft power and a rescue hoist with attachments. Rescue hoist is only used in cases of life or death or over water where no suitable alternative exists. Each medic carries an aid bag containing additional equipment.

6. Training. Medics are trained to the EMT proficiency level to the extent possible consistent with turnover of personnel in duty positions.

7. Communications. Air ambulance helicopters are equipped with radios supplied by the Civilian MAST Coordinating Committee (CMCC), which provide the capability to communicate with Emergency Medical Services (EMS) facilities.

B. Procedures

1. Requester:

a. The person requesting the assistance must first contact the civilian air ambulance service operating in the same geographic area covered by the MAST program.

b. If civilian ambulance service is not available or the local civilian ambulance service is not adequate for the mission, the requester may then contact the MAST unit at (270) 798-7266/7267), the 50th Medical Air Ambulance Company.

1) Read the entire evacuation request to the MAST operator on duty.

2) Ensure all information is given to the operator. Complete information will speed the response time.

2. MAST Operator:

   a. Record all available information.

   b. Read it back to the requester to verify accuracy.

   c. Relay mission request to Pilot-in-Command and follow established reaction procedures.

III. REFERENCE DOCUMENTS

Annex E (Military Assistance to Safety and Traffic) to Fort Campbell Military Assistance to Civil Authorities Plan (FC-MACAP), Fort Campbell MAST Plan (A Stand Alone Annex to FC-MACAP)

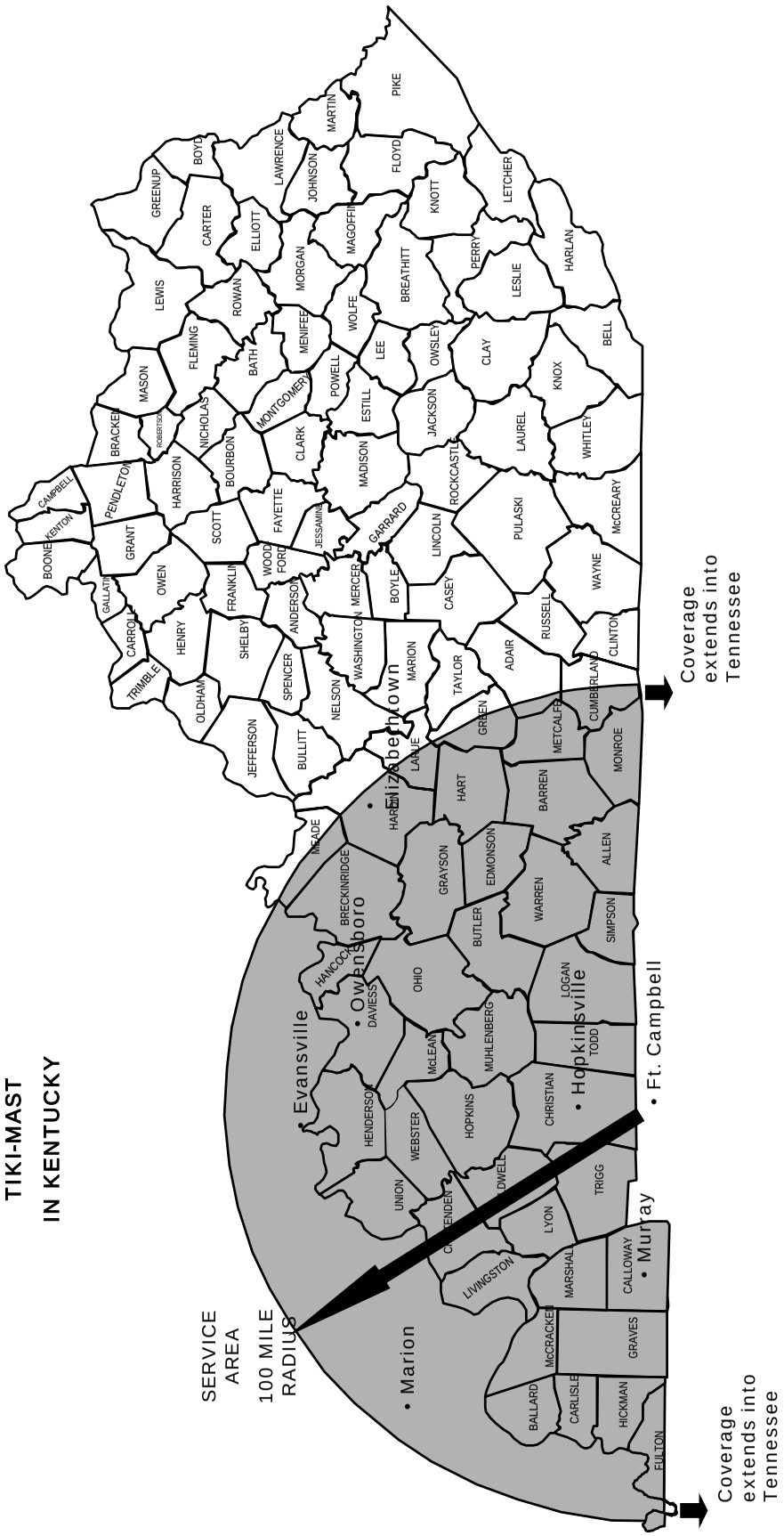
Army Regulation 500-4, AFR 64-1, Emergency Employment of Army and Other Resources, Military Assistance to Safety and Traffic (MAST), Headquarters, Department of the Army, Washington, D.C., Issue Number 1, May 29, 1987.

IV. MAP

MAP M-5-1-1 TIKI-MAST in Kentucky

MAP M-5-1-1

TIKI-MAST IN KENTUCKY



TIKI-MAST IN KENTUCKY

APPENDIX M-6
DISASTER MENTAL HEALTH PLAN FOR EMERGENCY RESPONSE

I. SITUATION AND ASSUMPTIONS

A. In a natural or man-made disaster or under national security conditions many events will occur which will necessitate the coordination and delivery of crisis intervention and disaster mental health services.

B. Crisis intervention and disaster mental health services are the immediate and coordinated provision of consultation, assessment, risk assessment, referral, defusings, debriefings, and on-site crisis counseling and/ or intervention to people affected by crisis or disaster.

C. The Kentucky Community Crisis Response Board (KCCRB) created under KRS Chapter 36 and recognized as the lead disaster mental health agency by the Health and Family Services Cabinet (H&FSC), Department for Mental Health and Mental Retardation Services (DMHMRS) (state mental health authority), Kentucky Division of Emergency Management (KyEM) and the American Red Cross (ARC), has the primary responsibility to provide disaster mental health services for the Commonwealth.

II. MISSION

The mission of the KCCRB is to insure an organized timely and effective response in the aftermath of crisis and disasters. Recognizing the psychological impact of these events on emergency responders, disaster relief workers, and affected citizens, the KCCRB promotes effective recovery efforts by: providing crisis intervention services which assist individuals to; understand disaster-related stress and normal reactions: develop adaptive problem-solving and coping skills; return to a pre-disaster state of equilibrium; and obtain referrals and follow-up services as needed.

III. DIRECTION AND CONTROL

A. As the designated lead agency KCCRB has overall coordination responsibility for this appendix, which complies with the provisions of KRS Chapter 36. All response will be undertaken using the National Incident Management System.

B. The KCCRB will operate from the Kentucky Emergency Operations Center (KyEOC) during all state level emergencies or disasters. The Executive Director of KCCRB, or designee, will coordinate all KCCRB activities.

C. ARC, mandated by Federal law as defined in 36 USC-5 to undertake activities for the purpose of mitigating the suffering caused by natural disasters and other emergencies, will liaison with the KCCRB in providing disaster mental health services in the aftermath of a disaster and may request support of credentialed team members to provide mental health crisis intervention and referral to individuals impacted by disaster.

D. Pursuant to KRS 210:040 DMHMRS, as the state mental health authority through KRS 210, recognizes and coordinates with the KCCRB as the lead agency for the Commonwealth of Kentucky in providing Disaster Mental Health Services and works with KCCRB to insure services are delivered to people affected by disaster.

E. KyEM will coordinate with the KCCRB, address delivery of services in the Kentucky Emergency Operations Plan (KyEOP), make this information available to local emergency management directors and emergency services organizations and provide necessary support by: alert notification, communications and on scene support.

F. KCCRB coordinates with the Education Cabinet, the Personnel Cabinet and the H&FSC when responding to crisis in schools.

G. All response by KCCRB are coordinated by using the National Incident Command System (NIMS).

IV. CONCEPT OF OPERATIONS

A. The KCCRB, through its staff and team provide: coordination, assessment, technical assistance, on scene support and other needed support in the Commonwealth during and after crisis or disaster. In all operations, the KCCRB complies with KRS Chapter 36.

B. The KCCRB maintains a published toll free 24-hour access phone number (888) 522-7228 to request a response.

C. The KCCRB credentials and maintains rosters of trained personnel to provide services. Trained responders will be deployed as needed following a crisis or disaster.

D. For individuals requiring additional assistance, appropriate linkages will be made with local mental health agencies. The KCCRB will assist the local helping network to plan for the longer-term recovery of the community at large. Federal assistance will be coordinated through ESF #8 “Health” of the National Response Plan.

E. KCCRB operations include the following level of events:

1. Local crisis or disaster within a limited area.

2. Major crisis or disaster declared by Mayor or/ County Judge/ Executive.

3. Major crisis or disaster declared by the Governor.

4. Major crisis or disaster declared by the President.

F. The KCCRB provides crisis counseling or disaster mental health services through local and regional team members. Team members are supported by, and respond under, the direction of KCCRB staff. When local resources are not sufficient to meet the need, KCCRB staff may respond.

G. Preparedness Functions:

1. Review KyEOP and KCCRB plans regularly.

2. Identify and maintain a current list of available resources.

3. Participate in exercises and training programs.

4. Offer continuing training for team members in the event of crisis or disaster.

5. Develop and distribute standard operating procedures.

H. Increased Readiness Functions:

1. Complete any preparedness function not fully operational.

2. Alert personnel needed for response.

3. Conduct additional training, as needed.

4. Obtain and provide necessary supplies.

5. Brief all personnel on individual responsibilities and chain of command.

6. Maintain immediate response capability and standby measures.

I. The following general organization of functions will be followed in a Presidential major disaster declaration or in other situations when appropriate.

1. Response Functions During (Impact) or Operational Phase:

(0-60 Days Post-Disaster-Immediate Services)

a. KCCRB staff will provide psychological support, risk assessment and consultation for state EOC staff through on-site support.

b. KCCRB will coordinate and/ or provide immediate crisis counseling services to survivors through outreach by KCCRB team members at The Red Cross shelters, service centers and other designated sites.

c. Assess needs for ongoing services.

d. Assist in transition to local mental health network.

e. Provide administrative grant support for the Department of Mental Health and Mental Retardation Services.

f. Conduct community meetings with survivors; disseminate public service announcements; prepare mass mailings (if appropriate); and provide training & technical support to mental health centers for beginning of regular services.

g. Provide technical support for mental health centers.

h. Provide ongoing training for mental health centers.

i. Provide training sessions, site visits, report writing, consultation, and consumer satisfaction surveys as needed.

2. Response Functions During the Regular Services Phase:

(61 days – 9 months post disaster)

a. Disseminate educational information on disaster mental health to community and survivors.

b. Support community representatives to develop cooperative networks for recovery.

c. Assess needs for ongoing services.

d. Assist in transition to local mental health networks.

e. Provide administrative grant support for the Department of Mental Health and Mental Retardation Services.

f. Conduct community meetings with survivors; disseminate public service announcements; prepare mass mailings (if appropriate); and provide training & technical support to mental health centers for beginning of regular services.

g. Provide technical support for mental health centers.

h. Provide ongoing training for mental health centers.

i. Provide training sessions, site visits, report writing, consultation, and consumer satisfaction surveys as needed.

V. ADMINISTRATIVE SUPPORT

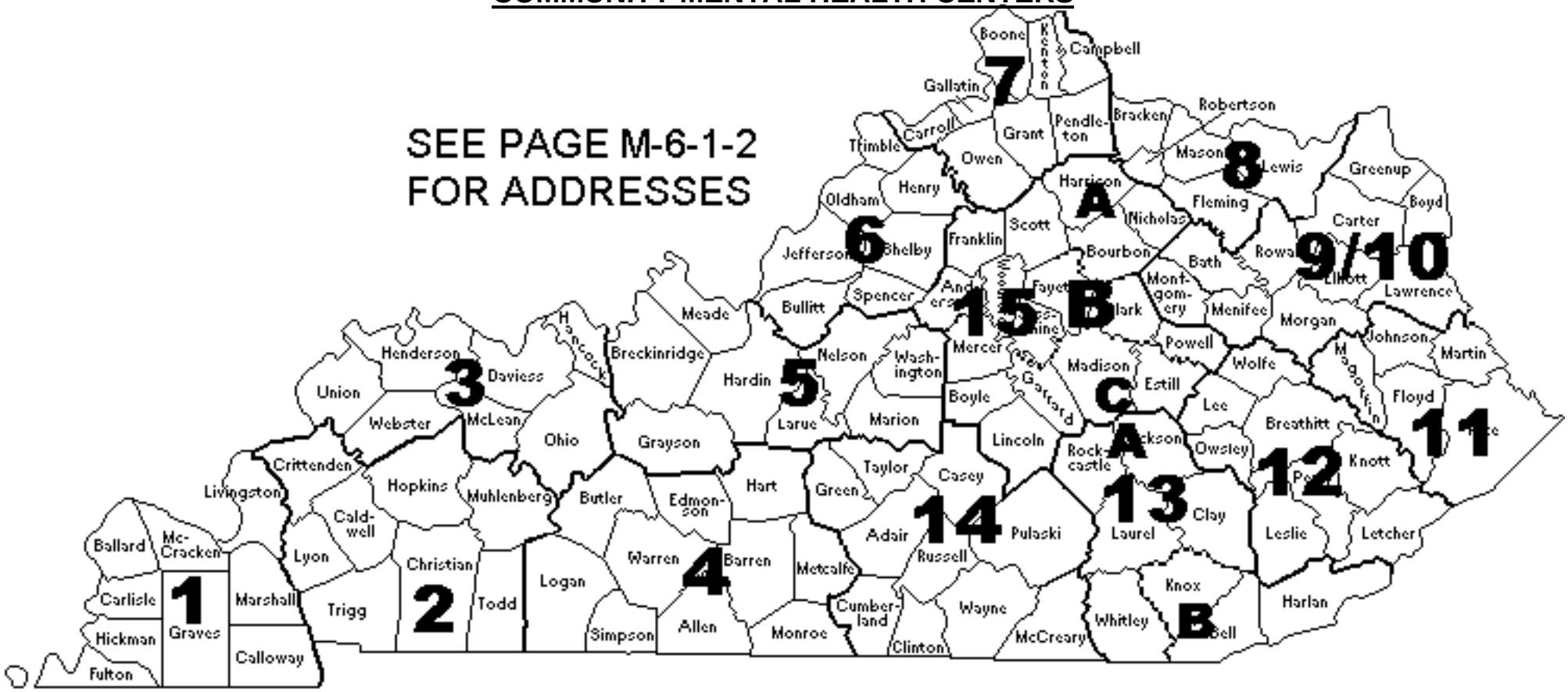
A. Administrative support will be provided by the KCCRB staff.

B. Augmentation and training of emergency organizations will be carried out as set forth in CPG 1-7 “Guide for Increasing Local Government Civil Defense Readiness during Period of International Crisis”.

VI. TABS

TAB M-6-1 Community Mental Health Centers

TAB M-6-1
COMMUNITY MENTAL HEALTH CENTERS



ADDRESSES FOR COMMUNITY MENTAL HEALTH CENTERS

DISTRICT 1

Western Kentucky Regional Mental Health/Mental Retardation Board, Inc.
1530 Loan Oak Road
P.O. Box 7287
Paducah, KY 42002-7287
(270) 442-7121

DISTRICT 2

Pennyroyal Regional Mental Health/ Mental Retardation Board, Inc.
735 North Drive
Hopkinsville, KY 42240
(270) 886-5163

DISTRICT 3

Green River Comprehensive Care Center
416 W. Third Street
Owensboro, KY 42301
(270) 684-0896

DISTRICT 4

Lifeskills, Inc.
822 Woodway Drive
P.O. Box 6499
Bowling Green, KY 42101
(270) 843-4382

DISTRICT 5

Communicare, Inc.
1311 North Dixie Avenue
Elizabethtown, KY 42701
(502) 765-2605

DISTRICT 6

Seven Counties Services, Inc.
137 W. Muhammad Ali Blvd.
Louisville, KY 40202
(502) 589-8600

DISTRICT 7

Northern Kentucky Comprehensive Care Center
P.O. Box 2680
Covington, KY 41012
(859) 331-6505

DISTRICT 8

Comprehend, Inc.
611 Forest Avenue
Maysville, KY 41056
(606) 564-4016

DISTRICT 9/10

Pathways, Inc.
P.O. Box 790
Ashland, KY 41101
(606) 329-8588

DISTRICT 11

Mountain Comprehensive Care Center
P.O. Box 1340
18 South Front Avenue
Prestonsburg, KY 41653
(606) 886-8572

DISTRICT 12

Kentucky River Community Care, Inc.
P.O. Box 603
Jackson, KY 41339
(606) 666-4904

DISTRICT 13

Cumberland River Comprehensive Care Center
American Greeting Card Road
P.O. Box 568
Corbin, KY 40702
(606) 528-7010

DISTRICT 13-A

Cumberland River Comprehensive Care Center
American Greeting Card Road
P.O. Box 568
Corbin, KY 40701
(606) 528-7010

DISTRICT 13-B

Cumberland River Comprehensive Care Center
Mounted Route #1
Harlan, KY 40831
(606) 573-1624

DISTRICT 14

Lake Cumberland Regional Mental Health/Mental Retardation Board, Inc.
120 Cundiff Square
Somerset, KY 42501
(606) 679-4782

DISTRICT 15

Bluegrass Regional Mental Health/ Retardation Board, Inc.
P.O. Box 11428
Lexington, KY 40575
(859) 253-1686

DISTRICT 15-A

Bluegrass West Comprehensive Care Center
191 Doctors Drive
Frankfort, KY 40601
(502) 223-2182

DISTRICT 15-B

Bluegrass East Comprehensive Care Center
201 Mechanic Street
Lexington, KY 40507
(859) 233-0444

DISTRICT 15-C

Bluegrass South Comprehensive Care Center
650 High Street
Danville, KY 40422
(606) 236-7072

APPENDIX M-7
PSYCHOLOGICAL EFFECTS OF DISASTERS ON RESPONDERS

I. SITUATION AND ASSUMPTIONS

A. In any major disaster there will be a high degree of stress on emergency responders.

B. Localized emergency situations may also involve increased levels of stress.

C. Federal support for this appendix will be provided under ESF #8 “Health”, of the National Response Plan.

II. CONCEPT OF OPERATIONS

A. Effects of Stress

1. Effects of stress on the emergency responder include an increased heart rate, elevated blood pressure and muscle tension. These produce a faster metabolism, added energy expenditure, and heightened concentration.

2. In small doses these effects can assist in the performance of emergency-related tasks.

3. Physical discomfort is possible if changes are extended too long, occur too frequently or become too intense. Physical discomfort symptoms include:

a. Gastrointestinal tension

b. Nausea

c. Muscle tremors or cramps

d. Heart palpitations

e. Ringing in the ears

f. Muffled hearing, or

g. Profuse sweating

4. Responders may also be energized by these physiological changes to the point they may want to work to the point of exhaustion.

B. REACTIONS TO STRESS

1. Emotional reactions to stress in an emergency or disaster include anxiety, fatigue, frustration, anger, irritability, hopelessness and moments of melancholy.

2. Responders have reported disturbances in work performance. These have been exhibited as short-term memory loss, the inability to use logic to solve problems, and difficulty in understanding or communicating with co-workers. These symptoms are often accompanied by feelings of being overwhelmed by the emergency task. Longer-term problems may include some of the same symptoms plus feelings of depression.

3. Following disasters or major emergencies, it is likely that there will be increased usage of alcohol and drugs (both legal and illegal). This needs to be discouraged.

4. The most severe form of an emotional reaction to an emergency or disaster is classified as a mental disorder known as Post-Traumatic Stress Disorder (PTSD). This occurs when event stress and occupational stress compound feelings of burnout.

5. Responders may also begin to withdraw from family and friends.

    a. This is because they feel their families cannot understand what the responder is going through.

    b. Others withdraw to protect family members from the terrible aspects of the response. This withdrawal leads to alienation, tension, and strain in the family.

    c. Some responders report conflict between their roles as disaster workers and family members when they have to be separated for an extended period of time.

C. <u>INTERVENTION</u>

1. Early Intervention activities are designed to assist workers in coping with the stress or event. The goal is to interrupt negative processes or minimize their influences.

2. On-Site Intervention or Crisis Counseling

    a. On-scene intervention may include actions by the incident commander; peers; and at times, crisis counseling by mental health professionals.

    b. Counseling to prevent prolonged exposure to stressors or to provide some measure of protection to workers through support and relief actions.

    c. Counseling by trained mental health practitioners can aid the responder who has become distressed in the performance of duties at the scene. Trained mental health professionals should do any after- disaster counseling.

3. Crisis Intervention Principles

   a. Isolate immediate problem and focus on it.

   b. Encourage the ventilation of feelings.

   c. Use positive rather than negative self-statements.

   d. Information gained through employee contacts can help determine if an employee can return to work, and if so, in what capacity.

      1) The preferred goal is the immediate return to full emergency duties and restoration of the normal working pattern.

      2) Alternately, reassignment to less distressing work or temporary release from disaster duties are options.

D. THERAPY

Therapy for distressed workers should be short term and emphasize an active, direct approach.

1. Workers become impatient with client-centered, non-directive approaches, but tend to respond favorably to behavioral management techniques targeted at symptom reduction.

2. Mental health professionals encourage removal of old stress reduction techniques (alcohol, drug use, etc.) before new ones can be successful.

3. The normal adjustment period following exposure to an intense and distressing experience may take many weeks and not all people adjust satisfactorily without some assistance. Monitoring is needed, either supervisory or medical.

   a. Favorable results are obtained when services are provided by trained Critical Incident Stress Debriefing (CISD) teams and by mental health professionals who are familiar with the personalities and jobs of emergency workers. Kentucky's Post Trauma Response Team (PTRT) can conduct CISD sessions in the state. CISD teams are trained to provide immediate counseling for emergency workers. The CISD teams can be requested by calling KCCRB at 888-522-7228. Before the state team can be activated a request for their services must be made. For a statewide disaster, the request could be made by the Governor's Office or the Attorney General's Office. On a local basis, the request could come from the County Judge-Executive, the Mayor, or Area/County EM Coordinators.

1) After incident counseling needs to be done within 72 hours, but best results are received by scheduling the session as soon as possible.

2) CISD sessions do not force anyone to talk about the occurrence but allow those who need to talk to do so. Anything said at these sessions is confidential.

3) Counseling on-scene needs to be separated as much as possible from the occurrence.

4) The news media is not allowed to participate in sessions for the responders. A separate session for the media may be arranged in certain cases.

b. Mental health services need to be available for those who need longer-term attention.

c. Those responders covered by Kentucky's Workers Compensation program are eligible for full payment of mental health bills if the mental health problems are directly related to the performance of disaster duties.

d. If a responder is temporarily unable to work due to direct exposure to a disaster; in addition to full payment of mental health bills, the responder is also eligible for other worker's compensation benefits.

e. State government employees and their families are eligible for help from the Office of Employee Assistance, Personnel Cabinet.

f. Following a Presidential-Declared Disaster, under PL 93-288, as amended 100-707; the state is eligible to request federal funds from the National Institute of Mental Health (NIMH) to provide special mental health services for disaster victims. This includes emergency workers. These funds may be requested by the Health and Family Services Cabinet (H&FSC).

g. Assistance is also available at Comprehensive Care Centers through the state (see Tab M-6-1). They are operated by the H&FSC.

E. PREVENTION

1. Identification and analysis of organizational stress. There are three major causes of organizational stress. They are:

a. Problems in role clarity and role conflict: Role Conflict occurs among workers who are unsure of their responsibilities in an emergency or disaster; role conflict occurs when a worker must face competing demands from other personnel, the media, or the public.

b. Chain of Command: When multiple response agencies are involved in the incident, it may be difficult to ascertain who is in charge.

c. Organizational conflict, either within or between organizations, over allocations of resources, responsibility or blame.

2. Pre-service and in-service training and planning activities to help workers become less vulnerable to stress and learn more about coping with traumatic events. This training should be as a companion to any regular training programs.

3. Any plan to assist workers in dealing with participation in a major incident should include an active affiliation between the organization and the mental health resources to which it has access. This affiliation should not exist only on paper.

a. Training can be accomplished through joint in-service activities. Mental health personnel can be incorporated into non-disaster emergency work such as on- site consultation for victims and referral.

b. Cross-utilization of resources between mental health agencies and emergency services should be encouraged.

III. ADDITIONAL GUIDANCE

A. Disaster Work and Mental Health, DHHS Publication No. (ADM) 87-1422, 1985 (Reprinted 1987)

B. Emergency Response to Crisis, Mitchell and Resnik, 1981

C. KRS Chapter 342

D. Prevention and Control of Stress Among Emergency Workers, A Pamphlet for Team Managers; DHHS Publication No. (ADM) 87-1496, 1987 (Reprinted 1988)

E. Prevention and Control of Stress Among Emergency Workers, A Pamphlet for Workers; DHHS Publication No. (ADM) 87-1497, 1987

F. Training Manual for Human Service Workers in Major Disasters, DHHS Publication No. (ADM) 86-538, 1978 (Reprinted 1983 and 1986)

G. FEMA Disaster Workers Can be Affected by Disasters, FEMA Publication L-156, September 1987

H. Returning Home After the Disaster, FEMA Publication L-157, September 1987

I. Human Problems in Major Disasters: A Training Curriculum for Emergency Medical Personnel, DHHS Publication (ADM) 88-1505, 1987 (Reprinted 1988)

APPENDIX M-9
CSEPP MEDICAL SERVICES

I. SITUATION AND ASSUMPTIONS

If there were an accidental release of Chemical agent at the Blue Grass Army Depot (BGAD), certain medical procedures specific to CSEPP are necessary, both as a precaution, and as treatment for symptoms.

II. MISSION

To provide and coordinate the provision of emergency medical services in response to a chemical event at the Blue Grass Army Depot.

III. DIRECTION AND CONTROL

A. During a declared “State of Emergency” in response to a chemical accident at BGAD, coordination of state agency emergency medical, public health and sanitation, and mental health services provided to the affected local government will be exercised a the state level. The Kentucky Health and Family Services Cabinet (H&FSC) will take the lead in coordination at the state level.

B. Designated state agencies will be assigned to coordinate with H&FSC to assist local government efforts in various disaster-related medical services, including, but not limited to the following.

1. Coordinated use of all available hospital resources, medical personnel and casualty collection sites.

2. A system for priority treatment of the contaminated and injured at both hospitals and casualty collection sites.

3. Identification and registration of the chemical casualties.

4. Coordinated assistance from the American Red Cross and other appropriate voluntary relief organizations.

C. Designated state agencies will be assigned to coordinate with H&FSC to assist local government efforts in various disaster-related public health and sanitation services, including, but not limited to the following.

1. Vector control to prevent disease and infestations, including pesticides.

2. Monitoring waste disposal, including contaminated foods.

3. Dispersing of drugs and medications to individuals in need of continuing treatment.

4. Inspection of the storage and handling of food, health and medical, and sanitation commodities and items essential to public health preservation.

5. Protection from contaminated and unsafe food and drugs.

6. Communicable disease control.

D. In response to a chemical accident at BGAD, local government emergency medical, public health, mental health, and sanitation services will be directed and controlled by the affected local government. This includes coordination of any health services that may be made available by the American Red Cross and other voluntary organizations.

E. Incident Hazard Analysis

1. If an incident occurs, a hazard analysis team will be established to do the following.

a. Evaluate current hazards.

b. Analyze any possible long-term effects.

c. The team will be comprised of representatives from BGAD, H&FSC, Madison County Health Department and representatives from Federal organizations. Other state agencies' representatives, Environmental and Public Protection Cabinet (E&PPC), and the Kentucky National Guard, may also be required.

IV. CONCEPT OF OPERATIONS

A. If the situation created by a chemical accident at BGAD is declared a "State of Emergency", "Emergency" or "Major Disaster", H&FSC will be responsible to coordinate all state agency disaster-related medical, public health, public mental health, sanitation and support operations and services.

B. The designated state agencies below are responsible to assist H&FSC by performing the stated disaster medical, public health, and sanitation and support functions during declared "State of Emergency", "Emergency" or "Major Disaster" operations.

1. Kentucky Division of Emergency Management will coordinate federal and other support, including military, as needed.

2. Kentucky National Guard will handle traffic and access control, medical care and water supply.

3. Kentucky Medical Examiner is responsible for body identification and disposition of remains.

4. State Fire Marshall will coordinate resources for mutual aid for fire fighters and equipment.

C. Public health and sanitation service provided to local government will be exercised by H&FSC during any declared “State of Emergency”, “Emergency” or “Major Disaster” situation. Each supporting state agency will function within its own internal structure and operating procedures under the direction and control of its agency head.

D. H&FSC will notify the state EOC of any requirements for federal medical and health assistance that may be available to the state. If such assistance is provided, H&FSC will serve as the state’s point of contact (POC) to the appropriate federal agency providing assistance.

E. BGAD will maintain its medical support capability as outlined in its CAIRA plan, which deals with on post emergency medical and health services.

APPENDIX M-10
STRATEGIC NATIONAL STOCKPILE PROGRAM

I. SITUATION AND ASSUMPTIONS

A. The federal government, through the Cabinet for Health and Human Services (HHS), Center for Disease Control and Prevention (CDC), has established a Strategic National Stockpile (SNS) Program, formerly the National Pharmaceutical Stockpile (NPS) Program. The SNS program is outfitted with medical supplies and equipment necessary to lessen the effects or assist in the response to a chemical or biological attack, or a natural disaster, effecting the population of the United States.

B. The Division of Strategic National Stockpile manages multiple emergency response programs.
   1. 12 Hour Push Package - This “Package” is designed for immediate deployment when time is critical to the response. The package is intended to arrive on site within12 hours of being requested by the state.

   2. Managed Inventory Supply (MI) – These packages are designed as a multi-phase response. These packages can be tailored to the incident and be available at the site of the incident 24 to 36 hours after being requested.

   3. CHEMPACK – These are pre-positioned stockpiles of Nerve Agent Antidote (See Appendix M-11). Additional CHEMPACKs can be requested and received utilizing the procedures outlined in this Appendix.

   4. Federal Medical Station (FMS) - An FMS will provide scalable (in size), modular, and rapidly deployable health and medical platform that may be used for the following functions:

      a. Non-acute medical, mental health, or other health-related needs that cannot be accommodated or provided for in a general shelter
      b. Conditions that require observation, assessment, or maintenance
      c. Chronic conditions that require assistance with activities of daily living but do not require hospitalization
      d. Medication needs and vital sign monitoring and who are unable to do so at home

C. In this Appendix, Tabs and Attachments, the terms “SNS assets, SNS medical supplies, and SNS material” are interchangeable and may represent any type of Health and Medical supplies including but not limited to pharmaceuticals, antivirals, vaccines, and other ancillary medical supplies.

D. All initial and resupply requests for SNS assets should be initiated by the Local Health Departments or Districts in coordination with Local Emergency Management, requests should be made to Cabinet for Health and Family

Services (CHFS) through the Kentucky Department for Public Health (KDPH) at 1-888-9REPORT (1-888-973-7678), State EOC 800-255-2587, or Kentucky Department for Public Health Department Operations Center (1-888-398-0013). CHFS will coordinate with KYEM and the Governor's Office to initiate formal request for SNS assets to CDC. Requests received at the State EOC will be routed to the KDPH-DOC.

E. Requests for SNS assets will only be made by the state once it has been assessed that local and state assets are insufficient to manage the incident, and the Governor has declared a State of Emergency.

F. The SNS medical supplies may be accompanied by CDC representatives who will provide technical assistance and support to Kentucky in the sorting, distribution, and dispensing of the medical supplies.

G. The CHFS has been assigned the role as the lead agency in managing Health and Medical logistical operations including but not limited to SNS operations, antiviral distribution, emergency vaccine distribution, and other ancillary medical supplies. KyEM will coordinate assistance and cooperation with all other state agencies to support CHFS efforts and will assume control of operation if CHFS is unable to execute this plan.

II. MISSION

To deliver the necessary medical supplies to an area experiencing a biological or chemical attack, or minimize the potential loss of life due to the lack of medical supplies and material resulting from a man made or natural disaster.

III. DIRECTION AND CONTROL

A. The CHFS will manage SNS operations by directing the Kentucky Department for Public Health (KDPH) to activate the Department Operations Center (KDPH-DOC) during all incidents involving SNS assets. KDPH-DOC will be the primary center for coordination of SNS asset requests from local jurisdictions.

1. Cabinet for Health and Family Services Emergency Support Team (ESF-8 Team) consists of trained staff for emergency response.

B. The Cabinet for Justice and Public Safety has been assigned the role as the lead agency for planning, coordinating, and executing Security for SNS operations at the Receipt, Stage and Store (RSS) site, and for the security of SNS assets during transportation between the RSS and the Distribution Nodes.

C. Receipt and inventory control of SNS Assets will be under the direction and supervision of a person holding a controlled substance license from the U.S. Drug Enforcement Agency.

D. A Unified Command System will be set up to manage all aspects of SNS operations.

IV. CONCEPT OF OPERATIONS

A. Definition of Event Levels

1. Level 1 Event: Catastrophic, affecting the majority of the Commonwealth's population or covering the majority of the state geographically.

2. Level 2 Event, Significant, affecting a significant portion of the Commonwealth's population or covering a significant portion of the state geographically.

3. Level 3 Event, Limited, affecting a limited portion of the Commonwealth's population, or affecting only an isolated portion of the state geographically.

B. Command and Control

1. State Responsibilities

   a. The Governor or the Governor's designee will request SNS assets from CDC upon recommendation of the Secretary of the CHFS or the CHFS designee.

   b. The State EOC will serve as the location for coordinating the allocation of State and mutual aid resources for all emergencies.

   c. CHFS will provide a representative to the State EOC during SNS incidents and will be the principle advisory to the State EOC for SNS related issues. CHFS representative will also serve as the primary link to the KDPH-DOC.

   d. CHFS will provide two RSS teams for warehouse operations and to work with the liaison teams provided by the Local Health Department (LHD) or District and County Emergency Management at the pre-designated Receipt, Stage and Store (RSS) sites. (Tab M-10-1 RSS site list)

      1) CHFS will establish a mobile operations unit at the RSS site to direct operations and conduct onsite coordination.

      2) If available the 41st CST will be requested to provide communications support to the RSS site.

      3) CHFS will provide a representative to the Unified Command at the RSS site.

4) CHFS RSS team should be prepared to deploy to support RSS operations at one of the pre-designated RSS sites.

5) CHFS RSS team should be prepared to deploy to support RSS operations in other states at the request of CDC and in support of the Emergency Management Assistance Compact (EMAC).

e. CHFS is responsible to provide the CDC with a list of individuals that are authorized to sign for SNS assets. (Tab M-10-4)

f. CHFS is responsible for issuing a single medical order or generic prescription as needed to allow for mass prophylaxis utilizing SNS assets. CHFS will consult with and follow the guidance of the CDC, HHS and FDA when issuing any medical order, protocol, utilizing an Investigational New Drug (IND), or utilizing an Emergency Use Authorization.

1) CHFS will distribute unlicensed antiviral drugs, vaccines or any pharmaceuticals for off label use under FDA's Investigational New Drug (IND) provisions.

2) Emergency Use Authorization – The FDA Commissioner may allow medical countermeasures to be used in an emergency to diagnose, treat, or prevent serious or life-threatening diseases or conditions caused by such agents, when there are no adequate, approved, and available alternatives.

3) CHFS will follow CDC guidance and the KDPH Public Health Practice Reference when issuing protocols.

g. Kentucky Transportation Cabinet (KYTC) has been assigned the role as the lead agency for planning and coordinating the necessary transportation assets needed by KyEM and CHFS to execute the SNS asset distribution plan. (Tab M-10-3)

h. If requested by another state or the CDC, the State EOC and the CHFS will coordinate the receipt of SNS assets at one of the pre-designated RSS sites located in Kentucky.

1) An Authorized DEA registrant from the receiving state will be required to sign for all SNS assets transferred to locations outside Kentucky.

2) The State EOC and the CHFS will assist in the transfer of SNS assets to another state, however, the receiving state may be required to provide some or all of the transportation assets needed to move SNS assets.

3) Cabinet for Justice and Public Safety will coordinate security for the SNS assets while in Kentucky.

4) CHFS will coordinate any request for assistance in storing and sorting the SNS assets.

i. If SNS assets destined for Kentucky are received in another state, the State EOC and the CHFS will coordinate with the receiving state for the transportation of those assets to a pre-designated RSS or Distribution Nodes within the Commonwealth.

1) KyEM is responsible for requesting the neighboring state make available its SNS designated warehouse and sorting facility to Kentucky, and that the neighboring state also provides security for the facility.

2) CHFS will provide a representative to sign for all SNS assets that are transferred to a pre-designated RSS or distribution node within the Commonwealth.

3) Kentucky Transportation Cabinet (KYTC) is responsible for coordinating for the necessary transportation assets needed by KyEM and CHFS to retrieve SNS assets from the receiving State's RSS. Tab M-10-1 is a list of possible RSS sites, both regional and within Kentucky that may be utilized for SNS operations.

4) Once the SNS assets have arrived at the RSS or designated distribution node, the CHFS will institute a program to track the warehousing, sorting, transportation and distribution of the medical supplies.

j. CHFS is responsible for coordinating and issuing a treatment recommendation when necessary.

1) The Commissioner of the Kentucky Department for Public Health will request that the Governor issue an emergency health declaration.

2) The Commissioner may also recommend to the Governor, suspension in part or whole of the following Kentucky Revised Statutes (KRS) and Kentucky Administrative Regulations (KAR), that address topics such as dispensing and labeling requirements, that may hinder an emergency response.

a) KRS 217, KRS 218, KRS 315
b) KAR 201, KAR 902

k. In the event the Commonwealth does not receive enough pharmaceuticals, antivirals, vaccines or medical supplies to meet all needs the Commissioner for Public Health will make recommendations to the Governor's Office for priority of use and distribution.

1) Apportionment and prioritization decisions will be based on current US Census Bureau population projections, as well as any event specific prioritization groups and the statewide Critical Infrastructure Personnel Matrix.

a) The statewide Critical Infrastructure Personnel Matrix is a consolidated list of the number of essential personnel identified to support critical infrastructure and continuity of government located in each County and maintained by KDPH.

2. County Responsibilities

a. The Chief Elected Official and the local Emergency Manager are responsible for managing a County's response to all emergencies.

b. The Local Health Departments or Districts (LHDs) will develop and maintain plans for the reception of SNS assets, requested through CHFS, and for distributing the supplies to treatment centers.

c. The Local Health Departments or Districts will coordinate all SNS planning and operations with County Emergency Management, and will be a principle advisor to the County Emergency Managers and the chief elected officials during incidents that involve SNS assets.

1) Planning and operations should address the following:
   a) Mass prophylaxis campaign
      (1) Points of Dispensing (POD)
      (2) Security
      (3) Transportation
      (4) Public Information and Communication
   b) Mass vaccination campaign
      (1) Mass Vaccination Clinic / Points of Dispensing (POD)
      (2) Security
      (3) Transportation
      (4) Public Information and Communication
2) Plans should provide for the treatment of the jurisdictions entire effected population to prevent further injury, loss of life or as the event dictates.

d. County Emergency Managers and LHDs are responsible for planning and executing transportation and security plans for the transportation of SNS assets from the Distribution Nodes to the Points of Dispensing (PODs)

and Treatment Centers.

e. Each LHD is responsible to coordinate all requests for SNS assets from all treatment centers located in their jurisdiction. Each LHD will submit a single consolidated request to KDPH-DOC.

    1) In the event this is a prolonged event or subsequent SNS supplies are needed KDPH-DOC will issue guidance for subsequent requests.

f. Each LHD is responsible to coordinate the dispensing and vaccination with all treatment centers located in their jurisdiction and to verify compliance with state issued treatment guidance and protocols related to the emergency or event.

g. Local Health Departments or Districts (LHD) whose jurisdiction contains one of the pre-designated Receipt, Stage and Store (RSS) sites are responsible to coordinate with CHFS to develop a local liaison team to assist the CHFS RSS management team.

    1) Local Liaison Teams should consist of 1-2 persons familiar with the County Emergency Operations Plan (EOP) and the LHD's SNS plan.

    2) Local augmentation for the RSS teams may be requested to support RSS operations at any of the pre-designated RSS sites within the Commonwealth.

h. In the event a County does not receive enough pharmaceuticals, antivirals, vaccines or medical supplies to meet all their needs the Local Health Department will make recommendations to the Chief Elected Official and County Emergency Management for priority of use and distribution.

    1) Apportionment and prioritization decisions will be based on current US Census Bureau population projections, as well as any event specific prioritization groups and the County Critical Infrastructure Personnel Matrix.

        a) The County Critical Infrastructure Personnel Matrix is a consolidated list of the number of essential personnel identified to support critical infrastructure and continuity of government located in each County and maintained by the Local Health Department.

C. Public Information

1. State Responsibilities

a. During declared emergencies all state agencies will coordinate all statewide press releases related to the emergency thru the State Joint Information Center (JIC).

b. CHFS will be the lead agency for the coordination of Health and Medical related information. CHFS Emergency Communications Plan details CHFS's response.

2. County Responsibilities

a. Emergency information to the public and media concerning the SNS deployment within the county is controlled through the local Joint Information Center (JIC).

b. Local health department personnel have been provided media contact information and training and will work with the locally appointed PIO in the JIC.

c. The local PIO and health department personnel will be in constant contact with the State JIC in order to ensure coordinated release of necessary information to the public and media.

D. Security

1. State Responsibilities

a. KyEM, Cabinet for Justice and Public Safety, CHFS and the RSS Host facility Security will coordinate a plan for the security of each RSS Site.

Deleted: .

b. KyEM, Cabinet for Justice and Public Safety, and CHFS will further coordinate for the security of SNS assets during transportation from the RSS to the Distribution Nodes.

2. County Responsibilities

a. County Emergency Managers and LHDs are responsible to ensure that a security assessment has been conducted and a security plan has been developed for all Distribution Nodes (DNs) and Points of Dispensing (PODs), as well as Treatment Centers and any other facility that may ultimately receive SNS assets should plan adequate security at their facility.

b. County Emergency Managers and LHDs are responsible for planning and executing a security plan for the security of SNS assets during transportation from the Distribution Nodes to the PODs and Treatment Centers.

E. Inventory Management

1. CHFS will utilize one of the following web-based inventory management systems as the primary means to track SNS material based on the event.
   a. RSS Inventory Tracking System (RITS)
   b. Vaccine Management (VACMAN)
   c. Inventory Resource Management System (IRMS)

2. CHFS will utilize an electronic Excel spreadsheet as a back-up system for inventory management.

3. CHFS will utilize a paper based system as an emergency system for inventory management.

4. Chain of Custody will be maintained by utilizing duplicate copies of all inventory transaction forms which all require a signature to complete the asset transfer. A copy of all transaction forms will be sent to KDPH-DOC to be reconciled.

F. Distribution & Repackaging SNS Assets

1. State Responsibilities

   a. KyEM and CHFS will coordinate for necessary labor needed; in the event Managed Inventory bulk packaging needs to be repackaged into unit of dispensing packaging.

   b. Local volunteers or contract labor may be used as staff for repackaging operations.

2. County Responsibilities

   a. County Emergency Managers and LHDs are required to develop plans for the receipt and distribution of SNS assets for their jurisdiction.

   b. The LHD will subdivide the shipment into the number and type of medical supplies required for each POD or requested by each Treatment Center.

G. Pharmaceutical, Antiviral, or Adverse Event Reporting System

1. State Responsibilities

   a. The CHFS will continue to work with CDC, HHS and FDA to implement the following systems in the Commonwealth.

      1) Outbreak Management System (OMS)
      2) Countermeasure Response System (CRS)

3) Adverse Events Reporting System (AERS)

b. As a back-up to these systems the Communicable Disease Branch, Division of Epidemiology will collect all reports, collate the information and issue reports daily or as needed to the State Epidemiologist for further distribution as needed.

c. Adverse events relating to vaccines will be reported utilizing the Vaccine Adverse Event Reporting System (VAERS). the Immunization Branch, Division of Epidemiology will collect all reports, collate the information and issue reports daily or as needed to the State Epidemiologist for further distribution as needed.

2. County Responsibilities

a. LHD are required to collect and report information relating to adverse events. Information should be coordinated by Regional Epidemiologists. Reports will be sent utilizing the systems outlined above or routed to the KDPH Communicable Disease or Immunization Branches thru the KDPH-DOC. LHD shall be required to conduct Epidemiological Investigations as needed.

V. ADMINISTRATIVE SUPPORT

A. The Strategic National Stockpile Coordinator, from the Department for Public Health, CHFS is responsible to review and submit updates to this Appendix and Tabs as needed. This Appendix will be reviewed at least annually.

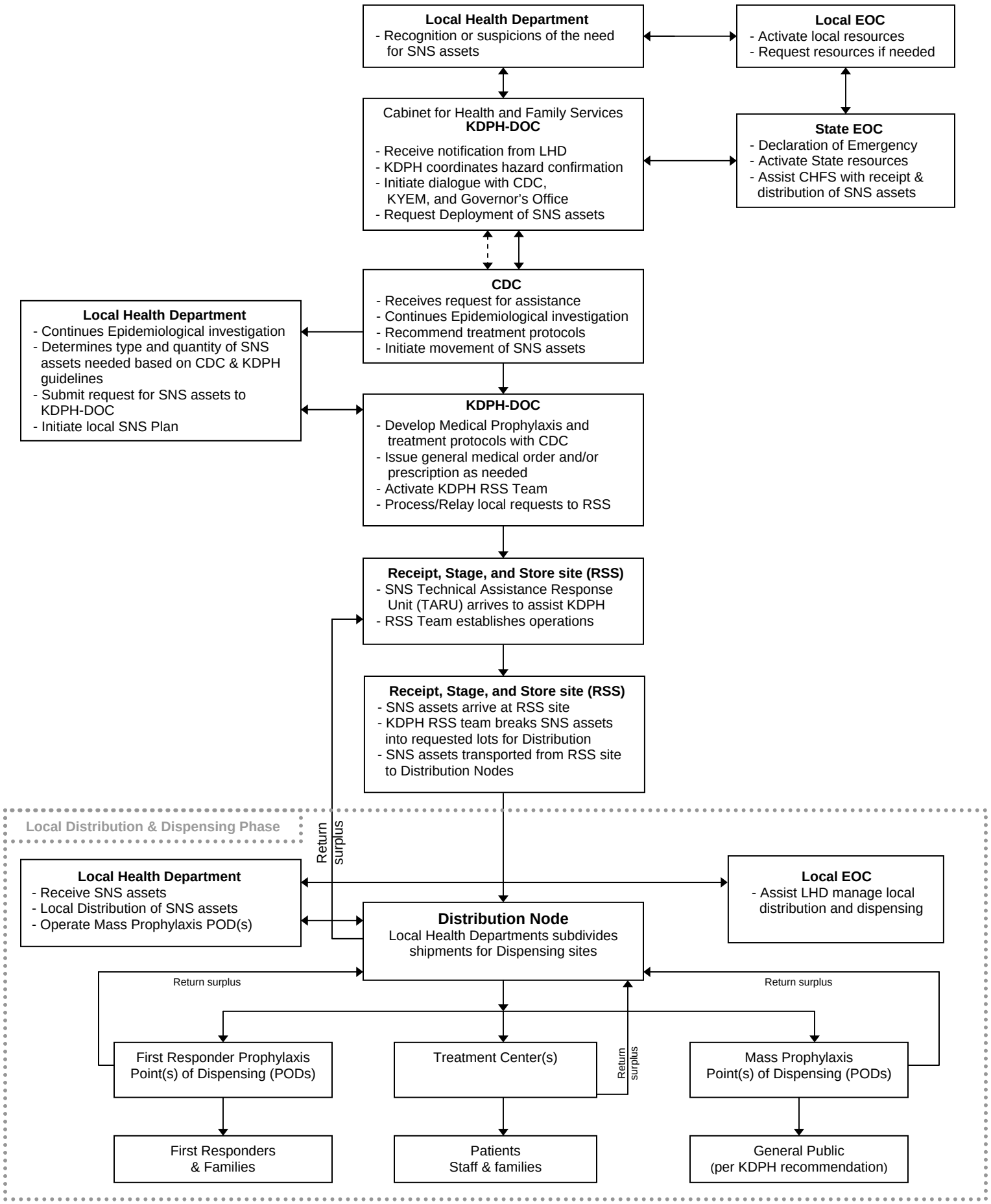
VI. TABS

A. Tab M-10-1 Regional and Local RSS Site List (Not for public distribution)
B. Tab M-10-2 Flow Chart for Activation of Push Package
C. Tab M-10-3 SNS Asset Distribution Plan (TBD) (Not for public distribution)
D. Tab M-10-4 Authorized Recipients List (Not for public distribution)
E. Tab M-10-5 Security Plan (TBD) (Not for public distribution)
F. Tab M-10-6 Repackaging Oral Medications (Draft only)
G. Tab M-10-7 Pandemic Influenza Anti-Viral & PPE Distribution
H. Tab M-10-8 Mass Vaccination Distribution

VII. REFERENCES

A. CHFS SNS Standard Operating Guidelines (SOG) (Not for public distribution)
B. CHFS Emergency Communication Plan
C. CHFS Emergency Support Team (ESF-8) program

Tab M-10-2
SNS Plan Flow Chart



TAB M-10-6
STRATEGIC NATIONAL STOCKPILE PROGRAM
Repackaging Oral Medications

I. SITUATION AND ASSUMPTIONS

A. An event has occurred requiring federal assistance including portions of the Strategic National Stockpile. Due to the scope of the event a portion of the material being shipped to the Commonwealth will arrive in bulk packaging.

II. MISSION

A. This section outlines how bulk SNS pharmaceuticals will be repackaged into individual regimens that will be delivered to the dispensing sites for distribution to the public. This effort will be managed by the Repackaging Manager and will occur at the designated RSS.

III. DIRECTION AND CONTROL

A. A Unified Command System will be set up to manage all aspects of SNS operations.
B. Repackaging operations will be coordinated by CHFS.
   1. Repackaging operations should be conducted under the supervision and coordination of a Registered Pharmacist.

IV. CONCEPT OF OPERATIONS

A. The Repackaging Manager will coordinate directly with the Materiel Manager. The function of repackaging includes creating individual, labeled regimens of specific drugs that will be staged for delivery by the Shipping & Receiving Manager.

B. According to recent CDC guidance, most of the oral medicines will arrive in prepackaged form. SNS staff will have to repackage bulk items when:
   1. Individual regimens in a 12-hour Push Package are insufficient;
   2. Shipments of prepackaged drugs from vendors are delayed; or
   3. Prepackaged medicines in the SNS are not effective against a particular threat and new drugs arrive in bulk.

C. Repackaging bulk drugs will remain in the SNS plan as a backup to situations where the prepackaged medicines are inadequate or ineffective. Repackaging personnel located at the RSS will complete the following operations:
   1. Unpack the SNS boxes and separate bulk medications from other medical supplies, such as surgical supplies or ventilators, that will be taken directly to hospitals.
   2. Count out individual doses depending on operational plans for multi-day regimen.

3. Put individual doses in small packages (such as dispensing vials or sealed “baggies”).
4. Label all individual packages.
5. These labels should be printed in advance if possible.
6. Assemble and load individual packages for distribution to dispensing sites.

D. Repackaging methods
   1. Division of Strategic National Stockpile (DSNS), now provides for three methods for repackaging bulk drugs: auto repacking using the high speed, high volume industrial packaging machine; auto repacking using the Kirby Lester KL50 Tablet Counter; and hand counting with hand held volumetric pharmacist trays. High-volume packaging machines
      a. Two high-volume industrial packaging machines can be requested if bulk supplies are expected. They require special training that will be provided by the Technical Assistance and Response Unit (TARU). They are described in the following capacities:
         1) Capacity: 2400-labeled individual regimens per hour per machine.
         2) Staff requirements: two CDC TARU members assisted by 6 local staff members. The total personnel required from KDPH is 12 per shift. Power requirement: 110 volts, 10 amps each.

      b. Kirby Lester tablet counting machines (modified Kirby Lester model KL50) Eight modified Kirby Lester KL50 tablet counting machines come with the Push Package. These are table-mounted versions of a commercial tablet counting machine found in many pharmacies. They are modified to count a fixed number of tablets with every touch of a foot pedal, and are described in the following capacities.
         1) Capacity: 1,000 regimens per hour per machine with hand-affixed labels.
         2) Staffing requirements: a 12-member team on each machine (to count; label; maintain supplies of tablets, baggies, labels; and pack repackaged drugs). The total personnel required from MSDH is 96 per shift. Power requirement: 110 volts, 1 amp each.

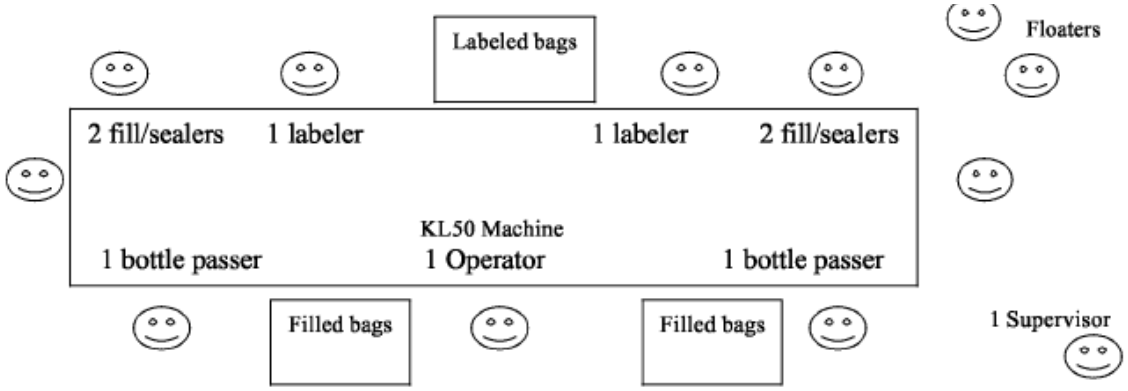
      c. Manual volumetric counting devices
         1) Manual volumetric counting devices can also be requested. This hand-held device looks like a melon scoop with different size scoops on each end; one-end scoops 10 ciprofloxacin tablets at a time, and the other scoops 14 doxycycline tablets (before using the device, users should determine what 10 ciprofloxacin and 14 doxycycline tablets look like in each scoop). The manual counters are described in the following capacities:
            a) Capacity: A filler can prepare an average of 150 regimens per hour. This consists of putting a 10-day regimen of ciprofloxacin or a 14-day regimen of doxycycline into a Ziploc bag. This does not include labeling.
            b) Staffing Requirements: 100 people operating in two person teams, switching between the tasks of counting and labeling. In this

manner, each person may reach 150 regimens per hour. The total personnel required by KDPH are 100 per shift. Power requirement: none.

2. Repackaging Output According to CDC guidance, KDPH can reasonably expect to produce 27,800 individual regimens per hour as follows:

Method	Capacity /hour	Staffing per shift	Total staffing (2 12-hr shifts)
2 industrial packaging machines	4,800	12	24
8 tablet-counting machines	8,000	96	192
100 volumetric devices	15,000	100	200
Total	27,800	208	416

E. Repackaging layout and procedure for the Kirby Lester machines



1. Machine operator at KL50 machine fills appropriate tablet amount into 2 oz. glass bottles. · Bottles are slid to 2 staff bottle passers.
2. Passer slides bottles to filler sealers and retrieve empty bottles to return to machine operator.
3. Filler/sealers fill 3” x 5” zipper type bags with bottle contents and place filled bags into box.
4. Bags are then labeled, counted, and rubber-banded into a unit quantity (e.g., 25, 50).
5. The supervisor announces rotations and overlooks all processes from a quality assurance perspective.
6. The floaters fill in for staff that need to break, move boxes from filling to labeling tables, provide bags to fillers, and keep the KL50 hopper filled with tablets.
   a. This layout was tested at the SNS Program Headquarters and produced 460 filled bags in a 27 minute period without labeling. This represents a fill rate of approximately 900 per hour.

F. Repackaging layout and procedure hand repackaging

1. The following is a repackaging layout for the hand held volumetric tablet counters.
2. The proposed chain of events for this design is as follows:

a. Two staff members work as a team counting and filling appropriate tablet amounts into 2 oz. glass bottles.
b. One staff member counts and fills bottles.
c. Second staff member takes bottles, fills 3” x 5” zipper type bags with bottle contents, labels the bag, places filled bags into box, and returns empty bottles to counter.
d. After half an hour, the team members switch positions and duties.
e. Pharmacists and supervisors announce rotations and overlook all processes from a quality assurance perspective.
f. This layout is based upon CDC guidance and upon tested methods from the SNS Program Headquarters.

G. Oral suspension preparation

1. Oral suspensions will be prepared at the dispensing sites.

TAB M-10-7
STRATEGIC NATIONAL STOCKPILE PROGRAM
Pandemic Influenza Anti-Viral & PPE Distribution
(Not for Public Distribution)

I. SITUATION AND ASSUMPTIONS

A. The World Health Organization (WHO) will declare Phase 4 of an influenza pandemic when there is a confirmed small cluster of limited human-to-human transmission of avian influenza, with spread being sustained but highly localized. The Federal Government will engage in Stage 2 of its response at this point. (See CHFS Pandemic Influenza Plan)

B. The Director of the CDC in consultation with the Secretary of HHS, or his/her designee, will determine when to activate the SNS to begin the distribution of critical medical materiel based on the WHO Phase characterization and the severity of the disease.

C. The Division of Strategic National Stockpile (DSNS) pandemic influenza response will include distribution of:
   1. Antiviral drugs
   2. Masks and respirators
   3. Additional items in SNS inventory: Personal Protective Equipment (PPE) and medical supplies (intravenous antibiotics, ventilators).

D. In this plan, it is assumed that the Commonwealth has sufficient staff and resources, including commercial partners to support statewide distribution of material.

E. CDC/SNS assets will be delivered to one location in each of the 62 project areas in 3 parts over successive days:
   1. Part 1 – Antiviral drugs
      a. Federal Antiviral drug distribution strategy will be a pro rata (based on the Commonwealth's population) deployment pushing product proactively to a single location in the Commonwealth. The DSNS will be delivering antiviral drugs to the Commonwealth prior to receipt of a request, the DSNS will be able to ensure that supplies are received before the need for assets becomes critical. Antivirals will be the first asset to be delivered to the Commonwealth, estimated to arrive within 7 days.
   2. Part 2 – Masks and respirators
      a. Masks and respirators will be allocated to the Commonwealth by DSNS pro rata and delivered immediately after antiviral drug distribution, estimated to begin arriving between 7 and 10 days after Part 1 is completed.
   3. Part 3 – Personal Protective Equipment
      a. PPE –protective face shields, gowns, gloves
      b. Medical Supplies and Equipment – IV antibiotics, ventilators and other medical items needed at the time of a pandemic influenza outbreak.

II. MISSION

A. To safely and rapidly distribute necessary antiviral medications, medical supplies and Personal Protective Equipment (PPE) to minimize the potential loss of life due to Pandemic Influenza.

III. DIRECTION AND CONTROL

A. A Unified Command System will be set up to manage all aspects of the Event response.
B. The Transportation Cabinet has been assigned the role as the lead agency for coordinating transportation of SNS material from the Receipt, Stage and Store (RSS) site to the Distribution Nodes.
C. All requests for transportation resources will be coordinated thru the State EOC.

IV. CONCEPT OF OPERATIONS

A. Definition of Event Levels
    1. Due to the nature of a Pandemic Influenza outbreak the Unified Command located at the State EOC will determine the event level and direct and coordinate resources needed or defined in all portions of this plan.
B. Security during distribution.
    a. Security of material during transportation from the RSS to the Distribution Nodes will be conducted in accordance with Tab M-10-5 Security.
C. Distribution Node Information
    1. See Tab M-10-3 Table 1 Distribution Nodes
D. Apportionment of antivirals, PPE or any other items related to a Pandemic Influenza response.
    1. All apportionment will be conducted utilizing the process outlined in Appendix M-10, Sub-Section IV, B, 1, k

V. REFERENCES

A. CHFS SNS Standard Operating Guidelines (SOG) (Not for public distribution)
B. CHFS Emergency Communication Plan
C. CHFS Emergency Support Team (ESF-8) program

TAB M-10-8
STRATEGIC NATIONAL STOCKPILE PROGRAM
Mass Vaccine Distribution and Vaccination Plan
(Not for Public Distribution)

I. SITUATION AND ASSUMPTIONS

A. Vaccine delivery is less dependent on pandemic stage than on vaccine availability, CDC recommendations, and KDPH priorities.

B. The federal government will purchase pandemic vaccine produced during the first few months (anticipated 3 to 6 million doses per week) and distribute it to states.
   1. Once vaccine is available, it will take several months to produce an adequate supply for the U. S. population. When first available, the federal government will distribute limited supplies of vaccine to states on a pro-rated basis. Kentucky comprises approximately 1.4 percent of the U.S. population, and can expect to receive 42,000 to 84,000 doses per week.

C. Kentucky Department for Public Health (KDPH) will control the vaccine and be responsible for storage, security, allocation, distribution, and tracking. This vaccine supply will initially be used to vaccinate priority groups. See Appendix M-10, IV, B, 1, k

D. The importance of consistent application of State of Kentucky vaccine priority groups must be weighed against local conditions. The local health department may request a vaccine priority group variance from KDPH based upon emergent needs.

E. The vaccine may be administered and distributed under Investigational New Drug protocols, requiring informed consent before administration, follow up for second dose if required, and monitoring for possible adverse events. Alternatively, vaccine may be administered under U.S. Food and Drug Administration

F. Emergency Use Authorization. Emergency Use Authorization procedures minimize the administrative burden and may be preferable to Investigational New Drug protocols to facilitate streamlined and efficient administration of vaccine.

G. The Director of the CDC in consultation with the Secretary of HHS, or his/her designee, will determine if and when to activate the SNS to begin the distribution of critical medical materiel based on the WHO Phase characterization and the severity of the disease.

H. In this plan, it is assumed that the Commonwealth has sufficient staff and resources, including commercial partners to support statewide distribution of material.

II. MISSION

A. To safely and rapidly distribute vaccines for vaccination to minimize the potential loss of life due to a Pandemic or Communicable Disease outbreak.

III. DIRECTION AND CONTROL

A. See Appendix M-10

IV. CONCEPT OF OPERATIONS

A. Vaccine Storage and Distribution
   1. KDPH will work with LHD to determine approved recipient sites that meets the vaccine CDC and Advisory Committee on Immunization Practices (ACIP) cold chain storage guidelines and protocols.
      a. Each LHD jurisdiction will designate a single location to be utilized as a central distribution node for vaccine during a Pandemic, Communicable Disease outbreak or other man-made or natural disaster.
      b. One location in each of the 14 Health and Medical Planning regions will be designated as the regional distribution nodes to be utilized in the event that centralized distribution is required.
         1) KDPH has purchased 14 vaccine refrigerators to be utilized at the regional distribution nodes.
         2) KDPH has purchased 28 vaccine cooler/freezers to be utilized with each Health and Medical Planning Region nodes for intra-regional vaccine transportation and distribution.
         3) KDPH has purchased 50 vaccine cooler/freezers to be utilized with the commonwealth for intra-state vaccine transportation and distribution.

B. Vaccine Monitoring
   1. The State Vaccine Safety Coordinator within the Immunization Branch at KDPH manages 12 regional field representatives that cover the entire state. The regional field representatives are charged with monitoring and providing guidance at the local level for vaccine management.

C. Security
   1. See Appendix M-10

D. Transportation
   1. Vaccine may be transported by the method outlined in Appendix M-10 and Tabs or it may be shipped directly to the Distribution Node from the vaccine manufacturer or distributor.

V. REFERENCES

A. CHFS SNS Standard Operating Guidelines (SOG) (Not for public distribution)
B. CHFS Emergency Communication Plan
C. CHFS Emergency Support Team (ESF-8) program

D. Kentucky Public Health Practice Reference

APPENDIX M-11
CHEMPACK USAGE

I. SITUATION AND ASSUMPTIONS

A. A CHEMPACK container holds nerve agent antidotes. These CHEMPACK containers have been deployed to a number of locations in Kentucky. Their purpose is to provide the Commonwealth and local governments a resource to increase their capability to respond quickly to a nerve agent event.

B. A CHEMPACK container holds nerve agent antidotes configured for both hospital and emergency medical service (EMS) use. Differences between the hospital and EMS configured containers are determined by the availability of Mark 1 auto-injector kits and diazepam for injection. Each container is designed to treat 1000 casualties exposed to a nerve agent however the EMS configured container contains primarily Mark 1 auto-injectors whereas the hospital configured container contains fewer Mark 1 auto-injector kits and greater bulk pralidoxime, atropine, and diazepam. Tab M-11-1 delineates an EMS-configured container and a hospital-configured container.

C. Each CHEMPACK container has an enclosed Sensaphone 2050®. This device monitors ambient temperature and provides a warning to CDC and state/local authorities should the temperature rise or fall above or below ideal storage requirements, respectively. In addition, the CDC will conduct periodic assay of the contents of the containers for product degradation. This constitutes the Shelf Live Extension Program (SLEP) administered through the Food and Drug Administration. It is through the combination of Veterans Administration pharmaceutical purchasing power and the SLEP that allows this program to be cost effective.

D. The CHEMPACK Project is administered and enabled at the Federal level by agreement of the Department of United States Health and Human Services (HHS), the Strategic National Stockpile (SNS) and the Centers for Disease Control and Prevention (CDC).

E. The Commonwealth of Kentucky has taken custody of Twenty-nine CHEMPACK containers. Twenty-two containers are of EMS configuration and Seven containers are of hospital configuration.

II. MISSION

Insure timely delivery of CHEMPACK containers to a potential afflicted or inflicted population.

III. DIRECTION AND CONTROL

A. The Health and Family Services Cabinet (H&FSC) will be the lead agency in deploying CHEMPACK containers.

B. All operations will be carried out using the NIMS management concept.

IV. CONCEPT OF OPERATIONS

A. Facilities participating in the CHEMPACK Project will have signed a Memorandum of Understanding between the facility and the Commonwealth.

B. The facility will be responsible for the storage and safeguarding of the CHEMPACK container in the facility and ensure compliance with applicable local, State and Federal regulatory laws, regulations and guidelines.

C. It is the responsibility of the facility to notify the Statewide SNS Coordinator within 24 hours should there be changes made to the contact information at the facility.

D. CHEMPACK containers may be opened at the discretion of the emergency department physicians at the host hospital and/or assets may be requested by EMS, CMED or other down-stream hospitals in the region of the host hospital. It is expected that hospitals will initially utilize their existing supplies of nerve agent antidotes before opening CHEMPACK containers unless EMS, CMED and/or hospitals anticipate exhausting their existing cache of these agents at which time CHEMPACK containers may be opened.

E. H&FSC or KYEM must be called immediately once the decision to open a container has been determined using (888) 9REPORT. KYEM can be accessed by calling (800) 255-2587. KYEM will notify the H&FSC Strategic National Stockpile Coordinator and his/her assistant that a container has been opened. KYEM will immediately contact the SNS program within one hour of an emergency deployment.

F. Hospital facilities and EMS operations that are not host facilities will request materiel from the CHEMPACK by calling KYEM at (800) 255-2587. Once H&FSC concurs that the CHEMPACK container should be open for deployment the host hospital will open the container and start movement of the needed supplies. The host hospital will immediately notify KYEM once the container is to be opened.

G. KYEM with KYDOT will arrange for the transportation of the apportioned case lots under escort by KSP if assistance from the state is requested, typically, transport will be handled with local assets from the requesting agency.

H. The locations of host facilities in the Commonwealth of Kentucky may be found in Tab M-11-2.

I. Case lots of the components of the containers have been pre-identified for distribution to field operations, EMS or non-host hospital sites. When EMS or non-host hospitals call H&FSC for CHEMPACK material, KYEM will inform the host facility to open the container on site and to distribute the material by color code, blue for hospitals and red for EMS use. Tab M-11-3 contains the inventory

and number of each type, blue and red, contained in hospital and EMS configured containers. Unlabeled cases will remain in the container and are for use by the host facility. Regional plans can be used to subsidize this process, as long as communication between CHEMPACK sites and KYEM, H&FSC continues in order to track assets.

J. At the discretion of the H&FSC and in consultation with the CDC and the host hospitals CHEMPACK containers may be temporarily transferred to a location closer to an event in which the risk of chemical agent exposure to the public is increased. The temporary location will meet all storage requirements for maintaining climate control. Appropriate security will be provided to prevent tampering with the container during transit and while temporarily stored away from the containers primary location. At the conclusion of the event all unopened containers will be returned to their host sites.

K. Each CHEMPACK container contains a Sensaphone. The Sensaphone will be used to transmit information concerning the deployment of the CHEMPACK to KYEM, H&FSC, and the CDC CHEMPACK offices.

L. The Statewide Strategic National Stockpile Coordinator will have responsibility for managing the implementation and day-to-day operation of the CHEMPACK Project for the Commonwealth of Kentucky.

V. ADMINISTRATIVE SUPPORT

Administrative support will be provided for the carrying out of the Appendix by other components of H&FSC.

VI. TABS

*TAB M-11-1 CHEMPACK Configuration

*TAB M-11-2 CHEMPACK Locations

*TAB M-11-3 CHEMPACK Receiving Documentation

*TAB M-11-4 CHEMPACK Container Contents

**(This document is FOR OFFICIAL USE ONLY. The Tab contains information, which may be exempt from public release under the Freedom of Information Act (5 U.S.C. 552).*